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NURSING HOME REFORM: PROTECTING CONSUMER INTERESTS

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

EXAMINING ISSUES REGARDING NURSING HOME REFORM AND PROTECTING CONSUMER INTERESTS

FEBRUARY 25, 1989
WORTHINGTON, OH

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NURSING HOME REFORM: PROTECTING CONSUMER INTERESTS

SATURDAY, FEBRUARY 25, 1989

U.S. SENATE,
SUBCOMMITTEE ON AGING,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Worthington, OH.

The subcommittee convened, pursuant to notice, at 11:00 a.m. at the Willow Brook Christian Home, Worthington, OH.

Present: Senator Metzenbaum.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Welcome. I want to say first how much I appreciate the Willow Brook Christian Home opening its doors to us today and making it possible for us to use this lovely facility and meet with many of those who are privileged to live in this facility.

This is a hearing of the Senate Labor and Human Resources Subcommittee on Aging.

Today's subject is important, controversial and disturbing. All of us are aging. And as we age, we become more vulnerable to stroke, Alzheimer's disease, to arthritis, to other diseases which may require long-term care.

Most of us would prefer not to confront the issue of nursing home care unless we are forced to. When we are faced with this decision—the decision to arrange for long-term care for a loved one or a friend—we begin to worry.

We worry about whether long-term care will be available if and when we need it. We worry about whether nursing homes will provide us with quality care if and when we need it. We worry about whether we will be able to afford that care if and when we need it.

Are these worries valid? Unfortunately, the answer is yes.

Now, there are many excellent nursing home facilities with caring staff and good administrators. We are in such a facility today. Residents receive quality nursing care in a pleasant environment.

But there is another side—an ugly side. Horror stories abound: Residents badly neglected, patients psychologically or physically abused, drugs administered improperly, poor sanitation, bad food, lack of nursing care, and a high turnover of poorly paid and untrained staff.

Daily papers are full of stories that document the sad state of affairs. Substandard care causes the closing of some nursing homes leaving residents and families to fend for themselves.

Recently in Toledo, fiscal mismanagement caused the shutdown of a nursing home forcing the transfer of residents to other facilities. During the shuffle, 18 people died. We are going to hear testmony on that tragedy today.

Upon investigation we have learned that some nursing homes will treat you better or worse based solely upon your bank balance. Some nursing homes simply refuse to admit patients requiring heavy care such as Alzheimer's victims, and the sky-rocketing cost of long-term care can quickly wipe out the life savings of most middle class families.

These are the problems we are here to discuss. This hearing is another step in a continuing process I have been involved in.

During the last session of Congress, I initiated a General Accounting Office study of the practice of several states which have made progress in eliminating discrimination in nursing homes against Medicaid patients. That report is due soon.

I have also asked a national panel of experts to draft recommendations on how to assure quality care in home and community-based alternatives to nursing homes. I am awaiting those findings.

In Congress we recently passed the nursing home reform amendments legislation designed to improve the status quo. But as you can see from this chart, the Health Care Financing Administration has missed deadline after deadline for establishing the guidelines necessary to make this legislation effective.

Give you an example. January 1 of 1988, missed a deadline to enforce alternative sanctions. March 1, public standards for nursing facility administrators, missed the deadline. July 1st, specify nursing home costs which may be charged to residents' personal funds and those which are covered by Medicare or Medicaid is applicable, missed the deadline. September 1st, establish requirements for nurses aide training and evaluation, missed the deadline.

October 1st, missed it with respect to setting minimum guidelines for appeals procedure for residents who are transferred or discharged.

Deadline missed with respect to developing criteria for preadmission screening of mentally ill and retarded residents and appeals procedures for residents adversely affected by screening.

Deadline missed with respect to developing criteria to monitor state waivers of licensed nursing requirements. And again missed the deadline with respect to providing regulations on alternative sanctions.

And in 1989 they have already missed the deadline with respect to specifying a minimum date of core elements and common definitions for resident assessments and guidelines for their use.

Missing another deadline for March 1, scheduled to be missed, to develop minimum qualifications for skilled nursing facility administrators under Medicare.

Someone is here today from HCFA, and we will inquire concerning that. It is only fair to say we appreciate his being with us and he certainly cannot be expected to accept personal responsibility for the missing of these deadlines which is a Washington activity rather than an area-by-area activity.

We are here to examine this issue up close, to collect testimony from people who have lived in nursing homes, from family members, from experts in the field.

Through their testimony and through the testimony of our other witnesses we will take an important step toward changing a system which we all agree desperately needs improvement.

One of our witnesses today will not be with us. I am disturbed to inform you that Barbara Seiling will not appear today.

Mrs. Seiling was the former director of nursing for the Extended Care Center of Toledo. That facility closed January 6 as a result of a $792,000 federal tax lien filed by the IRS against the owner who, according to press reports, served two years in the Ohio Penitentiary in the 60's for larceny and who also is recently indicted on 17 felony counts of theft of patients' money at the closed home.

Mrs. Seiling, who had been working diligently on her planned testimony describing the closure of the facility and the forced transfer of approximately 200 patients, has indicated to a member of my staff that she has been told that if she appeared here today and "said the things that need to be said," she never again would be able to work in a nursing home industry.

Frankly, that concerns me. That concerns me much.

I find it dismaying that fear of losing her livelihood should be added to the heartbreak and trauma Ms. Seiling experienced with the closure of the Toledo home.

One other point. It is a serious matter to intentionally interfere with or obstruct an inquiry of the United States Senate. We have laws on that subject.

With the information I have at hand, I am not certain that intimidation has taken place. I am certain that I will have my staff and appropriate legal authorities pursue this matter to find out if that was the case.

Now, today you may hear some phrases used such as OBRA and HCFA and PASARR. I am frank to tell you that since I have gone to Washington I have learned that people don't speak English anymore; they speak acronyms.

We have, just any kind of acronym you can think of and they expect the world to understand it.

I remember I was making a trip to the Soviet Union and the State Department was there for a briefing. And they started using these acronyms, just letters. And I said, "Wait a minute. I don't understand that kind of language."

So in an effort to help you if somebody uses those phrases, let me tell you that OBRA—it is not OPRA—O-B-R-A—stands for the Omnibus Budget Reconciliation Act, if that gives you a whole lot more. [Laughter.]

And HCFA, which is a little bit more important, stands for the Health Care Financing Administration which has to do with the moneys being made available to provide for health care.

And PASARR, which is P-A-S-A-R-R, stands for the Preadmissions Screening and Resident Review Procedures.

Having said that, that's enough of those phrases and acronyms, and I think it is time that we open this hearing and hear from our first witness, who is Halloween Barnes who is at the table.

Halloween, we are very happy to have you here with us.

I will ask each of the witnesses to be relatively brief, but I don't want to cut anybody off.

STATEMENT OF HALLOWEEN BARNES, A RESIDENT OF CARRIAGE INN, COLUMBUS, OH

Ms. BARNES. My name is Halloween Barnes. I want to clear that up. I was born on Halloween. They named me Halloween. And I am thankful that they didn't call me Pumpkin. [Laughter.]

They call me Hally for short. If the name was Pumpkin, they would call me Pie. [Laughter.]

I am a resident of Carriage Inn in Columbus, OH, and thank you for inviting me to talk. I didn't think I would be able to talk. I have been talking for two or three nights over this.

So that, yes, I have been in several resident homes. I have a very—it is not just a tale to tell you about some of the experiences I have had.

Now, in the Amber Home Care, health care, I didn't like it there because I couldn't afford to pay board and room for a mouse that were sharing my room with me. [Laughter.]

And then he was sitting there looking at the television and that went too far. I said, "Well, he would go that far and he will get in my bed. So I want to get away from there."

Well, then they moved me to the Capitol South Home, and then I had roaches to look at. And I said, "If they don't fall down on me, I will be all right" because they will bite you, and I just don't want to be bitten by a roach, which I have and I know they bite.

Well, then I heard about the Carriage Inn going to be opening up again. See, I was there when it was Clearview and I was very satisfied. They treated me fine, and I said, "This is my last home on Earth."

Well, I am back there now under that name of Carriage Inn, and I still say it is my last home on Earth because they treat you fine there. They saw to put us out and we couldn't see why, why they put us out, couldn't see a thing because it was clean and everybody was nice and the nursing aides and nurses were nice to us and told you the truth. My health was improving when I was there. But they put me out in these other places and just upset me completely. I am glad to be back there.

Now, one thing I would like to say, this I know, I experienced in the Amber Home Care, they had church service, that was nice. The activity room was across from the alley from the building and I used to go over there because I loved to play bingo. I am a gambler. [Laughter.]

And we had a lady from the state hospital there, that's what I couldn't understand why they brought those people there among us people that thought we had good services and all, upset us, make them go up the wall, too, with them.

Well, she was sitting in the room there by an old gentleman that had a cane across his lap. She asked him did he have a nervous condition. He said yes. She asked him three times, and the third time he said yes she got up and hit his cane across the head. Well——

Senator **Metzenbaum**. Why did she do this?

Ms. **Barnes**. She asked him did he have a nervous condition. He said yes. I don't know why she hit him across the head with a cane, but I guess she wanted him to change that word and say no or something. She hit him and, of course, she wasn't allowed in the activity room for three weeks.

Then the same lady, now, she goes up to the church service on a very nice Sunday and she is sitting by me, but I didn't know she was sitting there. And the minister, which there was two, was going around shaking hands and I had my hand stuck up there. I wanted to shake his hand because I was very glad to be at the church service.

And I heard this noise. I kind of ducked because it sounded like a lady. She slapped that preacher so hard he changed all colors. If you walked in there you wouldn't know what nationality he belonged to he changed that much. But he just said, "Lord have mercy."

I was in a wheelchair so that I couldn't get away quick. So I had to sit and wait until they started singing to ease the way because I was afraid she would hit me.

Now, that I just don't understand why those people got a nice place to be because I used to live on the Hilltop and I know. I used to go through those grounds and see that place. I have never known people that have been over there have—and have been treated nice. Why did they put them in the home with us people and get us all upset?

Senator **Metzenbaum**. When you had to move three times within the course of one year, was that pretty upsetting to you?

Ms. **Barnes**. Very much. I wanted—I asked them at the Amber House could I stay there until the Carriage Inn opened up but they wanted to move me to Mount Vernon, but I said that was too far with my people, what few I have in Columbus, Ohio to come to visit me.

Senator **Metzenbaum**. What did they tell you when you had to move from the first home to the second home?

Ms. **Barnes**. From the first home? Now, I have been moved from the second place I live now, I live up there and want to come back to Columbus because it was too far for my friends and my family to come. And so I come back. When I came back to Columbus they put me in Clearview. And I loved it because they treated me fine there.

Senator **Metzenbaum**. Let me ask you: What do you consider the most important factor of a good nursing home as compared to a bad?

Ms. **Barnes**. Good nurse aides and——

Senator **Metzenbaum**. Good nurse aides and——

Ms. **Barnes**. And nurses.

Senator **Metzenbaum**. And nurses.

Ms. **Barnes**. Yes. Now, the aides do just as much good as a doctor or good nurse would. If they would just treat us elderly people like we are human, don't come in hollering and screaming at us.

I can't stand people hollering at me. Now, like an aide comes in to wake us up, if he opens the door and says, "Good morning," that would wake you up. He could say it loud enough. He doesn't have to scream it, but he comes in and yells "Get up" as if I was an animal or something. That isn't good.

It is supposed to be our home. We wouldn't want that in our home. We want our home to be nice. Where I am at now, it is home, and it is nice. And so far the aides and the nurses around—of course, I get along with practically everybody because I talk so much, Senator, I talk all of the time. I get tired of hearing my own self talking. [Laughter.]

Senator METZENBAUM. What about those mice and roaches? Do you think they consider you friendly?

Ms. BARNES. No. Because that one that was sitting looking at my television, I moved my foot and he run up my bed. And I said, "Well, I will just have to tell everybody about you." And I did that time and they had the nurses tell me how fat he was. But I said he has been eating what I was supposed to eat because they had me on a diet. And he got fat and I got poor. [Laughter.]

Senator METZENBAUM. I think it is a nice compliment he paid he liked the same TV program.

Ms. BARNES. Well, he must. He liked the same programs I like. That's the trouble of it.

Senator METZENBAUM. Thank you, Ms. Barnes. Your testimony is very, very helpful. Thank you very much.

Ms. BARNES. Thank you.

Senator METZENBAUM. Are Bernice Jesser, Emerson Cole and Marianna Bihn here?

Thank you for being with us.

You are certainly welcome to stay.

Ms. Jesser?

STATEMENT OF BERNICE JESSER, DAUGHTER OF A FORMER NURSING HOME RESIDENT

Ms. JESSER. Yes, I am Bernice Jesser.

Senator METZENBAUM. Please proceed.

Ms. JESSER. Senator, my mother's age is 90 years old. She was a resident of Summit County Nursing Home for a year and a half.

Senator METZENBAUM. Why don't you bring that a little closer.

Ms. JESSER. Okay. Summit County Nursing Home in Monroe Falls. She was a resident there for a year and a half. The overall care there was extremely poor.

There was no personal care at all. It was more like pigeon-holing people. There was poor nutrition, there was no special attention paid to diets for salt free, mechanical. It was more like instead of substituting a food they would eliminate a food.

One evening it was frozen french fries that hadn't been completely fried. They had ice chips on them. Chicken McNuggets where the breading had been taken off and shredded for the people on mechanical diets.

One evening it was watermelon with a slab of jello and a muffin. One Sunday it was mash potatoes and a peanut butter sandwich.

The shortage of help was acute continually. And it was ongoing. They used agency people untrained at one time. They would run like four or five youngsters through there, probably high school boys out of school. I felt the women residents did not like being treated by aides that were young boys, didn't want to be given baths by the young boys.

The administration was very uncooperative. The Ombudsman was uncooperative with the families. It was always, "Your observation. It is your perception. These things don't exist."

The short of help. They were all being taken care of by untrained help in lifting, untrained help in cleaning, no sanitation procedures followed, no hand washing, no rubber gloves. Eye infections—I have seen a time when they wouldn't wash their hands to put their eye drops in.

I was told by the Social Activities Director not to contact the Ombudsman, not to contact Human Resources, that was her job in the nursing facility and that she would take care of those problems.

June 6, 1987, my mother was restrained in a wheelchair and she has never had any orders to be restrained except when she was ill. She was strapped in that wheelchair, a towel around her neck and towel around her middle section, two poseys, like seat belts strapped around her arms and her legs. And no one ever acknowledged why she was strapped in that chair, never could find out who did it and the incident was dropped.

In the Summer of 1987, they were without hot water. The facilities are new. I don't believe it is over three years old. That summer it was less than a year old and the boiler was out. Three weeks. There was no baths.

The owner told me they washed hands, face and bottoms and that was all that was necessary. Her comment was to me, "You work in an office. If the typing doesn't get done today, you can do it next week so what's the difference?"

I don't believe the boiler was out. I believe that they were short of help and couldn't give baths. I have seen a time when they have hired a young girl to come in on Saturday just to bathe the people. The facilities probably have 125 there.

Senator **Metzenbaum**. Is this a privately-operated facility?

Ms. **Jesser**. Yes. Crown Care out of Baltimore, Ohio.

Senator **Metzenbaum**. Baltimore, Ohio?

Ms. **Jesser**. Baltimore, Maryland, but this is the only facility, I think, that they have in Ohio.

The front doors are locked. You have to push buttons to get in and out. The fire exits are locked because they don't want to hear the alarm go off when patients accidentally hit those panic doors.

I asked what happened during a fire, and they assured me that the nurses at the desk, if they are at the desk, can automatically push a button and open those fire doors.

I was ill one night, November, the fire alarm went off. The doors to the room automatically shut. A woman in my mother's room got caught in a wheelchair. I couldn't open the door to pull her back in. I had to force her out in the hallway in order for that door to shut.

I don't know if I could have manually opened that door or not but my strength wasn't there. I couldn't do it.

I have seen them ignoring the lights, the call buttons. There aren't that many people that can actually help themselves. There is no recognition that someone needs help.

For months I saw towels on the electronic call box at the desk. I thought they were just towels you would be going to use but they were muffling the noise so the noise of the call buttons didn't disturb them.

The smells. I think it is common that at each entrance to the wings there are large tubs of dirty linens constantly. They are never missing. The smell, you walk by, you hold your nose.

I have seen their attitude on taking care of a person putting them in a geri chair, putting them in the day room because that's opposite the nurses' station and completely ignoring the—ignoring their cries, ignoring the fact they have to go to restrooms, ignoring any need, just put them out in the hall and leave them.

I know my mother's roommate was taken to the dentist in a wheelchair in a van and in sub-zero weather in her nightgown. They didn't give her enough time to change her clothes and they said, "You have got to go, it is your time." She went in a blanket wrapped around her. It was cold. She had a broken hip. That's what she was recuperating from.

They put her in that van, took her to the dentist's office and she sat there in her bare bottom in the dentist chair.

Another roommate, a blind woman in a wheelchair, sat, and as I left at 1:30 they brought her out under the awning to give her fresh air. I thought it was strange. I felt the woman never left her room. I left and went home.

I came back at 4:30. She was sitting out under that awning still. I said, "Freddy, don't you think you want to go in?" And she said, "I do." I told the nurse. "Don't worry about it, Freddy." I brought her back in and she came and told me that, "Oh, I checked on her. I took her meds out to her earlier. She was okay." No way she could have been okay.

I have a constant problem there in water not being readily available, water served in styrofoam cups and put on a—where the wash basin is across the room where the cupboards are.

I have seen juice put there. I have seen yogurt put there. I have seen cookies left there day in and day out. It is important nutrition that's left there and not fed to them.

I don't know if it is the help that doesn't realize that my mother did talk and walk but can't feed herself.

I have never seen the menus. I have never seen help cutting up meat. I have never seen anyone open the milk carton with a straw to help those people. I have never seen hot soup put in the cups so that somebody could drink it.

I have seen the time when the dining room has been closed because there wasn't enough help to bring these people into the dining room. I have seen the patio doors to the dining room open. There is no screens. I have seen the flies and the bees. The Ombudsmen had a meeting one day and they opened the doors and flies and bumblebees came in so somebody there doesn't know enough to keep the bugs out.

I have have seen wet floors constantly, wet floors with the little yellow sign saying "Watch out for wet floors."

The activities there are minimal, bingo and reading and arts and crafts. I would think that in Summit County out of 125 there were probably 15 people could participate in a type of activity like bingo.

There was no daily visits. I believe the staff there was in conflict with one another. I had the Activities Director come to me and ask me to call Becky Snyder, an Ombudsman, to tell her there were male patients there that hadn't been shaved or hair cut or hair washed. They smelled so bad and the stench was so bad they couldn't even bear to push them in and out of the dining room because they were so filthy.

But that's all over. My mother is at Rocky Knoll in Akron, Ohio. It is a beautiful facility. The love and care she gets there is what everybody deserves. It's a Presbyterian-run home. It is only 64 beds. We waited a year and a half to be able to get her there, transfer her. That's how long the waiting list is, two years.

Senator METZENBAUM. Let me ask you, why didn't you take her out of the home earlier?

Ms. JESSER. I couldn't find a bed anywhere else. I couldn't get her transferred. That was—that was the year and a half to two years waiting list.

Senator METZENBAUM. And is she a Medicare or Medicaid patient?

Ms. JESSER. Medicaid.

Senator METZENBAUM. How much does the facility get paid from Medicaid?

Ms. JESSER. I believe it is 1,600 or 1,800 in Summit county.

Senator METZENBAUM. Did you try to complain to anybody at the facility or anybody higher up?

Ms. JESSER. Yes, Senator Metzenbaum. The first care meeting with my mother, we sat down. It was to be an amicable meeting. It was like you are new at this. I have never had a confrontation of this type before, but when you sit down and tell them that you would like your mother to have yogurt in the morning and she doesn't like meat, or special dietary needs, and they tell you she gets that every day and you are looking at each other and you know she doesn't. I have never had any cooperation from the management, the staff.

The Summit County Ombudsman, the same way. They tell us we are running this place and we are running it just like we do our places in Maryland and you butt out. And that is their attitude.

Senator METZENBAUM. You say Ombudsman?

Ms. JESSER. Yes, Becky Snyder, Ombudsman, in Akron, Ohio.

Senator METZENBAUM. She is on the payroll of the State?

Ms. JESSER. Yes, sir, and she can't get cooperation from Summit County. I would call her first and she would talk to them. But there has never been any acknowledgement that they were wrong.

It's always, "We are short of help; we have a limited number of this; we have a minimum number of that."

On two occasions, I felt it was unsafe for my mother to be there. On Saturday I took her out of there and I didn't return her until after the 3:00 o'clock shift where I knew things had quieted down and hopefully the night shift would be there to take care of her. And I actually took her home because there wasn't enough help.

Senator METZENBAUM. What's your general view with respect to nursing homes and would a consumer guide help you, would stronger Ombudsmen help you? Would Health Care Financing Agency stronger enforcement help you? Would the State of Ohio stronger enforcement?

Ms. JESSER. Stronger enforcement. When there was no hot water there I called the Health Department. They made a visit. They made a visit two weeks after the phone call and they said everything was fine.

Senator METZENBAUM. Two weeks after the phone call?

Ms. JESSER. I said, "What do you mean everything is fine? There is no hot water." And their answer was, "Well, they are fixing it."

I don't believe to this day they made any attempt. I don't believe the boiler was out.

As far as Ombudsmen, that's the way to go. That is my salvation is the Ombudsman program. But they are probably understaffed and there aren't enough to police all of the nursing homes.

Senator METZENBAUM. Thank you very much. Your testimony is very telling, and I am glad to hear that your mother is in a nice facility now.

We are—we will now hear from Mr. Emerson Cole, Marianna Bihn.

Emerson, you are here in place of your brother Steve, as I understand?

Mr. EMERSON COLE. Yes.

Senator METZENBAUM. We are very happy to have you with us, Mr. Cole, and please proceed.

STATEMENT OF EMERSON COLE, SON OF A FORMER PATIENT OF EXTENDED CARE FACILITY

Mr. EMERSON COLE. Okay. Being the elder, my younger brother passed the task on to me. I think it would be because I have 35 years experience with the State and certainly understand how it operates.

There is evidently without a doubt a very poor system presently in place as it relates to nursing homes.

There is some lack of checks and balances that would allow a person like Mr. Swartz, who operated the nursing home in Toledo, of dubious criminal history, to have the lives of so many people in his hands. And his nursing homes, evidently, from what I have read, was just a sideline and a very, very small sideline at that.

How he continued to obtain licenses under his circumstances baffels me. The man continued to get licenses and there was certainly evidence not only by the nursing home that closed down in Toledo but by a previous nursing home that he was operating.

My dad died. He was buried a week ago today. But before he died, I was very, very appalled of the way he was treated. He worked hard. Coal mines, railroads and foundries, raised six children to get degrees in college, taught the work ethic.

And yet when he became ill it was required that he be reduced to the state of a pauper before he could obtain any aid that he very, very sorely needed.

He had an amputation in 1980. We did not put him in the rest home in Toledo until he had a severe stroke in 1987.

And if I would have known then what I know now, we wouldn't have put him in even with a stroke because the care that he got was certainly less than adequate.

The lady to my right that has just finished, her story relative to underpaid, untrained, noncaring personnel can be amplified in a number of homes, especially that facility in Toledo.

My father was transferred to Heartland on the 6th of January. He was the last person transferred out of that place in Toledo. And to take old people—he was 81 when he passed—to take them and then to have this transfer trauma, he didn't know where he was going, he didn't know why he was going; we didn't know where he was going, we didn't know why he was going.

And I think it's certainly a transgression to the intelligence of a family when you load up elderly and infirm people in the middle of the night and bounce them off of some unknown place without even the decency to notify their relatives where they are going.

I am sure as I can be that this transfer trauma certainly had a specific input into the alarming number of deaths that occurred to the people that were transferred from that place.

I dealt with the Toledo welfare quandrant and it was atrocious. It was atrocious. They said have this man reduce his net worth down to $1,500.

We just buried him for $4,100. Any time a person's assets that he has saved and worked for has to be gotten rid of in order to get some help and you say $1,500, that's what his—all he can be worth.

And then a funeral costs 35 to $4,000. I think it is an atrocity upon the people of the State of Ohio. I am certainly very concerned that I would ever have to go into a facility like that.

Now, the facility in Heartland was well run. It was very efficient. It was well managed.

Senator **METZENBAUM**. This is the second place?

Mr. **EMERSON COLE**. This is the second place. But he was transferred sometime on January the 6th, like I said, the last person out.

I was at that home on Christmas Day visiting my father. Nobody had the courage, nerve or the intelligence to inform me that there was going to be a move. We might have had some opportunity to place him.

No. He ended up out in the middle of nowhere, confused and lonely and increasing the visitation miles double and triple.

My brother from Cleveland, he had to drive 220 miles one way. My sister from Detroit, they had to drive 170 miles one way. In other words, he was sustained by his children who visited him on a regular basis. And when that was taken away, he certainly lost the will to live.

I certainly think that the elderly and the sick ought to have some rights. They are not cattle. They are not vermin. They are not any kind of commodity to be woke up unceremoniously in the middle of the night and transferred to God knows where.

They didn't know where. And we had one hell of a time trying to find out where the place was ourselves but we finally did and he lived exactly six weeks after that.

Senator **Metzenbaum**. How did you learn about the nursing home's closing, Mr. Swartz's?

Mr. **Emerson Cole**. My brother Steve called me, and I went directly to the place where they were going to send him and I arrived there about an hour after he got there.

Senator **Metzenbaum**. That was when they moved him. Wasn't there some earlier announcement that the nursing home was closing because they couldn't pay their bills?

Mr. **Emerson Cole**. Well, the first knowledge that we had of that was Christmas when my father, very kindly old gentleman, he said, "You know, these poor folks only are getting half of their pay." And I said, "Dad, don't worry about them getting half of their pay. Worry about your kin." But he was worried.

That was the first indication that we knew something was wrong. This was the 25th of December, and they had moved him out as of the 6th of January and he was the last one out.

And I sincerely believe after 20 years with the Civil Rights Commission that there was some concern relative to race.

It seems like those with money and those that were white went to that place in Toledo, and those who were without money and those that were of color ended up in rural areas that were almost impossible for their relatives to reach.

Senator **Metzenbaum**. What community did your dad move to?

Mr. **Emerson Cole**. He was moved to Heartland Nursing Home of Indian Lake, and we all had to grab maps because nobody had ever heard of it before.

Senator **Metzenbaum**. Where is Indian Lake?

Mr. **Emerson Cole**. It is somewhere near Bellefontaine.

Unidentified Person. It is about 100 miles from Toledo.

Mr. **Emerson Cole**. But this move certainly buried him. We buried him not with the 1,500 that we were allowed to have as his estate, but we buried him with some dignity.

And that's all we had asked from the beginning that the man that had worked hard making train wheels, to give ammunitions to the coast during wars, the guy that crawled under the ground three miles down to mine coal, be allowed to live a few months out of his life in dignity and this was not allowed.

Senator **Metzenbaum**. Go ahead. Do you want to say something?

Mr. **Emerson Cole**. And the thing that was very trying is that he went in there and all of a sudden he got a staph infection. This staph infection appeared at an opportune time and then it disappeared at certain times.

And I asked, "Does he have a staph infection?" Nobody knows. Nobody knows. And then the next time you come in there, they have got staph infection on the door.

Now, he did have a roommate that was extremely ill, who is living, to the best of my knowledge, and we thought the staph infection was for him. But when it come time to make transfers, they conveniently—my father all of a sudden had a staph infection.

And his care, his care left a lot to be desired and his dignity was stripped. And the Welfare Department in Toledo, Ohio, which I worked for five years back in the 1960's, leaves a lot to be desired as it comes to caring for the elderly.

And like I said before, not to be repetitive, this is our last parent. We don't have any more parents to lose. But had we known that this kind of traumatic situation was going to take place, we would certainly have made other arrangements for him outside of the nursing home.

And just to you, Senator, there should be some very, very pointed looking into the method of how these rest homes are run, how they accept people, why their waiting lists are so long and the screening criteria. And I tell you what, it was almost impossible. I guess we were lucky to get dad in any rest home at all but it is a problem.

Senator METZENBAUM. When were you informed that they were going to close on December 25?

Mr. EMERSON COLE. I wasn't informed. I was just informed that the staff received half pay. I was told that by my dad.

Senator METZENBAUM. I see. But they did not—I thought some announcement was made around December 25 that the facility was going to close.

Mr. EMERSON COLE. Not to my knowledge unless—

Senator METZENBAUM. When did you learn it was going to close?

Mr. EMERSON COLE. Unless they made an announcement to my brother Steve. He lived in Toledo. He was in range where he could walk around there everyday.

Mr. STEVE COLE. December 29 I received a call.

Senator METZENBAUM. December 29 you received a phone call?

Mr. STEVE COLE. Yes, saying the nursing home was closing and to come over there and see where he was going to be moved to.

Senator METZENBAUM. And did you go over there? What did they tell you?

Mr. STEVE COLE. They had him—at first they said that he might be going to Cherry Hill and I should go over there and talk to the people at Cherry Hill and that the people at Extended Care said they had talked to the people at Cherry Hill Nursing Home which is about 10 blocks from Extended Care.

When I went over there, they said they were only taking two people and they didn't have his name down. They didn't know anything I was talking about. I went back and they said he was going to Drexel, Ohio.

Mr. EMERSON COLE. Deschler.

Mr. STEVE COLE. They had him moved four times in four days and they waited until after the holidays. And like I said, he was the last person, one of the last persons to leave the nursing home. And he was asking me were they going to send him out on the street.

Senator METZENBAUM. What was the ratio mix of this facility?

Mr. STEVE COLE. To the best of my knowledge it was about half and half.

Senator METZENBAUM. And—all right.

Mr. STEVE COLE. But we weren't informed. When my dad went to Extended Care, he didn't have a staph infection. And we were under the impression that the person in the same room had the staph infection. Only until we found out that Heartland was the only facility in the State would accept him and that's when the people at Heartland told us he had a staph infection which was contagious.

And they didn't say anything about the staph infection at Extended Care. We didn't know anything about that until after he was scheduled to move and that's when they told us that he had a staph infection and we still don't know where that came about.

Senator **Metzenbaum**. Thank you very much. Your testimony has been extremely helpful and thank you for working here with us.

We now have with us as our next witness, Mrs. Bihn, who is the Ombudsman for the Toledo area. We are happy to have you with us and please proceed.

STATEMENT OF MARIANNA "SAM" BIHN, THE BOARD AND CARE INVESTIGATOR, NURSING HOME OMBUDSMAN, TOLEDO, OH

Ms. **Bihn**. My name is Marianna "Sam" Bihn. I am the board and care investigator/Nursing Home Ombudsman caring for Northwest Ohio.

I have worked for the program since March of 1988. Prior I was a volunteer Ombudsman.

My job entails receiving, investigating, verifying and resolving complaints pertaining to residents' rights, House Bill 600 in nursing homes.

On December the 28, 1988, I was notified of Extended Care Nursing Home's closing in Lucas County by the State long-term care Ombudsman Roland Hornbusbel. The facility was closing due to financial problems.

Myself and Mrs. Kirk, the nursing home Ombudsman, were instructed by the relocation team to inform each resident that the home was closing and that they would be moved when the beds became available.

This was the most difficult task I have ever had to do in my entire life and in my career, to inform residents that their home was closing, to hear their cries for help. But most of all, to be helpless was very devastating to me.

The confusion that followed was unbelievable. By noon families were coming into the facility. Some were hysterical. Others had looks of disbelief. One family explained, "I just heard it on the news."

One resident wanted to commit suicide, while another refused to leave. One resident was transferred to another facility that had no bed available, and the resident was returned back to Extended Care.

The staff was also helpless. One staff person came to me and informed me that a resident's family wanted to pay the bill for the month of January. The family was in such a state of shock that they thought that payment would help.

Residents were transferred without families being notified. Families cried, "I just got called an hour ago and was told they were moving my mom. I wanted to go with her but they took her away already." Others asked, "Where is my mother's money?"

Although our local county prosecutor is investigating into possible discrepancies, I had no answers for the residents, the families, nor the staff.

Some nursing home administrators were up on the floors of the facility going into the residents' rooms checking under their sheets of the residents to view their bottoms without their consent.

Senator METZENBAUM. I didn't get that.

Ms. BIHN. The administrators were checking into individual residents' rooms pulling up the sheets that the residents were in the bed checking for decubiti, breakdown of the skin, without the residents' consent and stating that, "We can't take this one, there is decubiti."

One of the administrators confronted me for an authorization release for the release of a resident. I then directed the administrator to obtain the relocation leader, and I also contacted our state offices regarding this matter. They did not authorize it, and I do not have that authority to authorize.

In conclusion, residents in nursing homes have the right to a 30-day notice unless there is an emergency closing. The residents at Extended Care clearly lost their rights during this closing.

I leave you with this question and thought: What constitutes an emergency closing? Thank you very much.

Senator METZENBAUM. Very powerful testimony from each of these witnesses this morning and it really tears your heart out.

Mrs. Bihn, what authority does the Ombudsman have? Who arranged for the moves? Was it the Welfare Department? Was it the home where they are presently located? And were the administrators that were coming in sort of looking over and seeing which ones they wanted to choose and which ones they didn't want?

Ms. BIHN. Yes, they did. There were some administrators—I am not saying all administrators, obviously, there are good and bad. Some of the administrators were actually up on the floors making choices, comparing lists so that they wouldn't backtrack each other.

I felt quite helpless and tried to uphold the residents' rights as far as I could with 199 residents to be relocated and two staff locally, our job was quite difficult. It was utter chaos and confusion in trying to help the families, consult the residents, it was——

Senator METZENBAUM. You heard Ms. Jesser speak before about her mother. That's a different geographical area?

Ms. BIHN. Yes, it is.

Senator METZENBAUM. What authority does the Ombudsman have? Can the Ombudsman say to the State "Withdraw the license of this facility"?

Ms. BIHN. In a case like hers, my area, we do not have the authority to have licenses revoked, no.

Senator METZENBAUM. Well, can you—even though you don't have authority to have it revoked, can you say to the top Ombudsman in Ohio—who will be here testifying with us today—"We think it is criminal to permit this facility to continue operating, we think they ought to lose their license"?

Ms. BIHN. Absolutely. We can say that to our Ombudsman.

Senator METZENBAUM. What?

Ms. BIHN. We can refer that to him, yes.

Senator **Metzenbaum**. Have you ever done that?

Ms. **Bihn**. Yes.

Senator **Metzenbaum**. Has there been any follow up?

[No response.]

By your answer, I gather that there hasn't? I don't want to interpret that lack of response.

Ms. **Bihn**. I am not aware of the communications back to me in follow ups.

Senator **Metzenbaum**. What would be one general recommendation you would make to this committee that might be helpful to implement improvement of nursing home patients' care at the national level?

Ms. **Bihn**. Adequate staff training. Also, my concern is I was involved with the relocation at Extended Care and I have a concern regarding the emergency. What constitutes an emergency? Is it financial problems or is it an earthquake?

I would recommend that this be looked into. I think it needs to be really addressed because of all of the families, the residents that were just devastated by this upheaval in such a quick manner.

Senator **Metzenbaum**. Twenty-one deaths occurred out of a resident population of 200 during that period. Do you feel that some of those deaths were contributed to by the manner and method of moving the patients around? That's a very high percentage of deaths to occur.

Ms. **Bihn**. I believe so, sir.

Senator **Metzenbaum**. You would think so?

Ms. **Bihn**. I would think so.

Senator **Metzenbaum**. I thank you very much for your testimony.

I want to say to these witnesses, I think it takes a lot of courage to testify. I think it is sometimes embarrassing. I think your testimony is particularly significant, particularly helpful.

I think your testimony, Mrs. Jesser, Mr. Cole, the first witness we had was extremely helpful and I appreciate your candor in reviewing with us the problems that are faced in this field.

It's just heartbreaking. They are spending at the national level—how much money did you tell me? About 20 to $25,000 per year for care of these people. I have some concern that some of these profit-making operations are just that. And we don't have the kind of responsible care or concern for the patients that they should have. We will follow up more on this subject before we conclude.

Peggy Kirk has arrived with her sister Tammy Hudson. Peggy, we would be very happy to hear from you. You are the sister of a former nursing home resident in Batavia, Ohio. Come forward, please.

Peggy, we are happy to have you with us. I understand you had some difficulty finding the location?

Ms. **Kirk**. Yes.

Senator **Metzenbaum**. Please proceed. We ask the witnesses to take approximately five minutes to tell their story.

STATEMENT OF PEGGY KIRK, SISTER OF A FORMER NURSING HOME RESIDENT, BATAVIA, OH

Ms. Kirk. Okay. My brother was nine years old when they found out he had juvenile diabetes and he lived a pretty normal life up until about when he was 38 years old, I think it was about three years ago, and he started having kidney failure which they couldn't do anything about. He was losing his eyesight. And he did end up losing both kidneys.

He had to go and gave up his house, sold his car, moved into different apartments trying to make ends meet on the income he was drawing on disability.

He did get a kidney transplant. That kidney functioned for approximately a month or two months and he lost that one, also.

So he is going through a lot of depressions over the two years that he was in this state. And he got to a point where his eyesight was just about gone, and he is on dialysis. He had to go three days a week to the hospital for treatment of dialysis which was four to six hours a day.

He started having problems with both feet and legs and couldn't care for himself, couldn't get around on his own. His wife had asked him for a divorce which added to the complications.

In July of this past year, he was put in the hospital to take care of his feet or try to resolve something on the gangrene that had come to his feet. While he was in there, the social worker had called and told us that he would need to be placed in a nursing home where—he couldn't be cared for at home, he needed 24-hour care.

He had had a heart attack and was on sliding scale insulin and a lot of different reasons and they said it would be best for him to go into the home. She had told us at that point they could place him in a home or we could find one ourself. And she said, "If you are willing to look for a home and place him in one, that's fine. Otherwise, the hospital and social workers just find whatever they can find available and they put him in there. You have no say-so."

But my sisters and I and the rest of our family said, "No, we will find a place, you know, close to where we live and, you know, we think he would be happy with."

My sister, Tammy Hudson, took off work the very next day and just made calls. She took a list of a page for each nursing home she called and made a list. We thought this would probably be something that, you know, we would be able to place him in a home in a matter of days or maybe weeks.

On that day, she contacted 36 nursing homes and put him on the waiting list and gave them any details that we had and told them, you know, I don't know, that they needed to talk to a social worker at the hospital. And we expected that, you know, he is on the waiting list and we would probably hear something, you know, from some of them.

And days passed and weeks passed and we didn't get any place from the nursing homes and we phoned back on different occasions to ask, you know, what his status was. They didn't have any vacancies.

And the first lead we got in a nursing home with a male bed was in Blanchester, Ohio. So we went that same day to tour the facility and they showed us the room and they said, "This is the room he would have," and talked to the Director of Nursing and went through everything with her that we knew to tell her.

She told us everything, you know, we needed to hear, and she basically led us to believe that this room was his if he wants it.

So the next morning my sister Tammy and me made calls and tried to get things going. And she called the nursing home that afternoon, the very next afternoon to let them know, yes, we definitely do want that room. And they said, "Oh, that bed has already been taken by someone else that was ahead of him on the waiting list," which was never mentioned when we toured the facility.

So we didn't take that to heart real bad. We just thought, well, we messed up. We should have acted in the morning instead of waiting in the afternoon.

We talked with the social worker at the hospital probably four days a week to see what she found out compared to what we found out. Any time we got a lead on a nursing home that even acted like they may have a vacant bed we phoned the social worker at the hospital and said, "Call them now. We think they may have a bed." We would tell them what we knew as far as his history, and beyond that, the medical needs and his medication would go through her.

And every time we would find out, yes, they have x-amount of male beds empty, we would ask her to call them and she would talk to them. And then we would find out they don't—you know, he isn't accepted there for whatever reason. And a lot of excuses we got was the one where I called and they said, "We have three beds empty." And he met all of the criteria as far as being skilled or not skilled or intermediate or not intermediate, and that changed from week to week with his care, and so did some of the regulations with Medicare and Medicaid.

We would call the nursing home that had the available beds and they said, "Yes, we do have the beds available." And I said, "Oh, great." So I called the social worker and asked her to call them. And she called me back saying, "No, they really don't have a bed. They are not staffed to take care of him."

So I called the lady back at the nursing home, and she said, "Well, he really needs more care than we are staffed to give. He needs 24-hour care."

That was obvious because that was what I was told, he had to be placed in a nursing home. I contacted this particular nursing home three different times to find out they did have vacant beds for a male and I begged them, you know, to take him and the lady, you know, just one excuse right after the other, they are not staffed, he would be too much work for our nurses here and on and on and on.

And at the same time we are going through this with the nursing homes. I had a list of ones I contacted weekly and so did my sister Tammy.

Out of the 36 we chose, the ones that were closest to the area where we lived, and I called certain ones every week and I knew exactly how many beds, male beds he had ahead of him. They would tell me he is fourth on the list to get a male bed or he is third on the list and we kept a running list.

She had a list of certain nursing homes and I had a list and we each called every week to see, you know, has anything changed, has he moved up on your list or what because at the same time we were making all of these calls the doctors were going in every day, not just one doctor, but two or three of them asking my brother, "Have you found a place to go yet" because he was hospitalized at this time and he couldn't be released until we found a nursing home.

The social worker said she did get an updated list each day that would tell there are certain number of available male beds but she preferred not to send anyone there. They were not of any quality. Unless you don't come up with something she wouldn't have a choice.

The doctor would ask him every day, "Have you found a place to go? Have you found a place to go? You know, you need to get moving on this."

He is totally disabled, almost blind. He did lose a leg. He was confined to a wheelchair, couldn't walk. He couldn't do anything on his own, and they are going in every day asking him, "Have you found a place to go yet?"

We asked the doctors and social workers, we told them we work seven days a week trying to find a place. Please don't go in and depress him anymore than he already is.

He was 38, 38 years old and had already had to accept the fact he gave up his kids, his house, his wife wanted a divorce, and, you know, his job, he had lost everything at that point. And we said, "You know, he has accepted he is going to have to go to a nursing home. Don't keep hitting him over the head with it every day."

I asked the doctor, I finally said to one of the doctors, "It may help if a doctor calls a nursing home. They sometimes have a pull that we don't."

The doctor said, you know, "Give me one with a bed." And I gave him one I had been contacting on three different occasions, and I said, "They have a bed right now that they are telling me, you know, they aren't staffed to take care of him."

And he said, "They can't do that." And the doctor called the same nursing home, and he called me back in five minutes, "They are blowing smoke but they aren't going to take your brother."

I said, "What did they tell you?" He said, "They were at their Medicaid level, they couldn't accept any more Medicaid patients." But he said he didn't believe them.

This went on for, like, three months. We would get a lead on a nursing home in a different county. We ran him on like four or five different counties, in different counties.

We got a lead on one in a different county from where we were, and we went and visited that and they had a bed. They said, "Get back to us within a couple of days and the bed is yours." We said, "We will take it."

I mean, the facility was okay and, you know, we talked to my brother and he was okay on it. We talked to the social worker and asked her to call and, you know, get things going.

She called us back and she said, "I don't think they know what they are talking about. If I were you, I would stay away from that nursing home." So we dropped that one.

And then after about three months of him sitting in the hospital waiting to find a place to go, we got a call from the social worker and she said she had a lead on one.

Well, in the meantime—let me back up a little bit. I took any lead that anybody would give me on calling a nursing home. It didn't matter whatever they said, maybe this person could help you, we would telephone and say, "Look, this is what is going on. Can you help us?"

And after about two-and-a-half, three months, a person I worked for gave me a lead of a friend of his. She was able to give me some leads, and one of those was the Ombudsman Pro Seniors which I had never heard of and didn't know anything about.

So I called this lady there and told her what was going on and she said, "They can't do that. If they have a vacant bed, male bed, and they meet all of the criteria, is either skilled or intermediate, it is illegal for them to say 'We can't take him because he is too much work.' They can't do that."

I said, "Gosh, for three months we have been fighting this and we find beds available all of the time." And about the same time we had some contacts with one in Clermont County and we had someone in the family that actually worked there and had said he has been on the waiting list there long enough to have gotten a bed and there was x-amount of beds available on a certain date.

So we started making all of the necessary phone calls, and they really gave us the runaround there, and they finally told her, "Look, he is too much work for the nurses. They are not going to take somebody in there that needs the care he needs."

He was on 28 different medications. He was confined to a wheelchair. He had to have help in and out of bed. They had to wait on him. We thought that's what nursing homes were all about.

This went on for three months and I worked real close then with the lady, with the Ombudsman and Pro Senior. And she was able to give me different information on some nursing homes, like, you know, if there had been any patient abuse or any claims against the nursing home that were legit or not legit. So she was the only person for three months that had given any of us any help at all.

Senator **Metzenbaum**. The Ombudsman?

Ms. **Kirk**. Right. She was great. I said to the social worker, "Look, I have run across this lady." And I told her who she was, and the social worker said, "I have never heard anything about it then." I said, "Gosh, she has the list of all of the nursing homes and if you find one you like, you can call her and she will tell you anything she knows on it. She is allowed to do that."

I thought it was great information. And my social worker said she had never heard, you know, she knew nothing about it. So she took the phone number and name and she said maybe that would come in handy for her sometime.

So then the social worker called right after that, she said, "I have a lead on a nursing home, you know, down in Cincinnati which, you know, wasn't close to you," but she said, "maybe you could take it until you find something different."

So we took off work and went to look at that one. And it was in a really bad area and they had—it was a locked facility. They locked the doors as you go in. They had bars on the windows. I thought this was, you know, to keep patients from trying to get out, but the bars were on all of the lower windows so I don't know. It was just a bad area of town.

The smell. The place was the pits. It was filthy. I had never seen anything close, and we had been at a lot of different facilities. So my sister and I stood there waiting for somebody to come and help us.

We were standing in the hallway. Some of the patients were in chairs in the hallway. And we waited probably five or ten minutes and we didn't see a nurse or anyone other than some housekeeping people that were on the floors. We were real leery of the situation so we decided, you know, it was bad news. And we said, "Let's get out of here as soon as somebody comes in and unlocks the doors." So we asked one of the housekeeping ladies to help us out and she did and we left.

And I called my social worker and she said, "I don't know anything about the facility, but if you don't take it, you better have an alternate." I said, "You can't believe what this place is like. There is no way we can put him in there." And she said, "Well, I will lose my job if you don't come up with something different. He is going to have to go there."

And I called the Ombudsman and I talked to her and I called her in advance to see what—you know, what she knew about it and she said, "I prefer you to go and see the facility first and then call me and we will talk. If they do have an available bed, you owe it to yourself to look."

I called her and I said, "Gail, tell me about this place." And she said, "Tell me what you thought." And I went on and on forever. "Well," she said, "I will tell you it is rated the worse in the State of Ohio."

And I said, "How do they—how does it stay open?" I mean, it was terrible.

So then I called my social worker and told her all of this and she said, "Either come up with something different or that's where he has to go." And this is after three months of us—I mean, we looked—we have stuff we didn't bring but we have files. My sister has a file——

Senator **Metzenbaum**. What did you finally do, Peggy?

Ms. **Kirk**. Just within a couple of days, one of the staff attorneys from the Ombudsman phoned me at work and said that he had been notified that they were going to place my brother in that place that we had looked at. And I said, "Oh, my gosh." I said, "It is bad."

He knew the whole story. He says, "We are going to fight it." He says, "I don't know if we can beat it." He says, "We will start in on the location because it would be a hardship on the family."

I said, "We are willing to take the location away from us, you know, until we find something closer. We will live with that, but," I said, "it is the pits."

He said, "I know. We will fight it but I don't know what we can do." But then he also told me, you know, the hospital says he has got to get out, his time it up and he needs to leave.

And the guy, the staff attorney told me they have to give you written notice from the hospital when they want you to leave and your Medicaid was running out. They can't come in one day and say, "Today is your last day." "When you get the notice in writing, you call me immediately and we will start things in motion."

Then the very next day I happened to think—they had changed his care from skilled to intermediate, back and forth a number of different times, and when they would, we would call the facility and say, "He is skilled now." And the social worker said, "Let them know he has changed for some reason."

The next day I called one that was intermediate which was what he changed to the care and she says—I told her—I spilled my guts to this lady and told her everything that had been going on.

I did mention to her, I said, "I have been working with Ombudsman," and I said, "I know the rat race we have been going through is illegal. I just am at wits end."—

She said, "I may have something for you." She called me the next day and they accepted him at that nursing home which was in Clermont County which was a nice nursing home and it was close to where we lived. That part all worked out. Three months and one week he sat in the hospital.

Senator METZENBAUM. He was lucky he had two sisters that were that dedicated.

Ms. KIRK. My whole family. He had three sisters and another brother.

Senator METZENBAUM. Is he in the home now?

Ms. KIRK. He passed away in December. I guess for us, you know, we made phone calls, we did everything we had to do still. And the hospital was an hour from where any of us lived. We all lived real close together and we still spent days working, going to visit him and trying to deal with him.

We asked him—he did need counseling because of all of his medical problems, his divorce and all of that. And we asked, "Could you get him some psychiatric counseling to help him through all of this?" And we did that and the social worker said, "That is going to make it harder to get him in a nursing home."

Senator METZENBAUM. Did you tell them you might need some yourself?

Ms. KIRK. That's the last thing I told her, we will all need counseling.

Senator METZENBAUM. Your testimony is very helpful, and I am very grateful to both of you for being here.

It portrays very graphically the frustration of trying to find a nursing home. And then we know the other side of the coin and that is some of these nursing homes are totally inadequate and not doing the job well.

I would like you to tell my staff privately after this hearing the name of the facility down in Cincinnati or near Cincinnati so that we might do some follow up. Thank you very much and we appreciate it.

Our next witnesses are Roland Hornbostel, State Ombudsman, the Ohio Department of Aging, Columbus, Ohio; Mary Halfacre, Vice-president, National Coalition of Citizens for Nursing Home Reform, Columbus, Ohio; Conrad Woody, National Center and Caucus for Black Aged, Member of Board of Directors and Director of Human Services for CMACAO, Columbus, Ohio.

I am happy to have each of you with us. Since you are in the professional area, I am going to hold you to the five-minute limit or I am going to be here about the time I should be at dinner tonight and I don't intend to do that.

The audience should know that all of this testimony is being recorded. It will be a part of the official records of the Labor and Human Resources Committee of the United States Senate. And so it is not just somebody saying it, nobody hearing about it. We will use it subsequently.

Mr. Hornbostel, we are happy to have you here. We will have some questions, but grateful are to you for participating and joining us this morning.

STATEMENT OF ROLAND HORNBOSTEL, STATE LONG-TERM CARE OMBUDSMAN FOR THE OHIO DEPARTMENT OF AGING, COLUMBUS, OH

Mr. Hornbostel. Thank you, Senator Metzenbaum. My name is Roland Hornbostel. And for the last two years I have been the state long-term care Ombudsman for the Ohio Department of Aging.

For the 10 years previous to that, I was part of a regional network of Ombudsmen in Ohio and I specifically worked in the Cleveland office from 1977 to 1986.

The Ombudsman program in Ohio is basically made up of 12 regional offices, professional staff and volunteers. They are not state employees. I do want to make that correction.

But the programs are designated by each of our area agencies on aging throughout this State to serve as part of the office of the Ombudsman.

Senator Metzenbaum. Whose payroll are they on?

Mr. Hornbostel. They are on the payroll of that individual organization, Senator Metzenbaum. For example, here in Columbus, Catholic Social Services is the Ombudsman program. Beverly Gross from that program is here.

In Cleveland, it is Luther Metropolitan Ministry. In Cincinnati, as you just heard, it is a legal services organization called Pro Seniors. So it varies around the State. In each of the 12 regions there is a different sponsoring agency for the program.

Senator Metzenbaum. And you are—for whom do you work?

Mr. Hornbostel. I work for the Ohio Department of Aging.

Senator Metzenbaum. But each of the individual Ombudsmen are really not part of your organization, they are quite independent of you except they work with you?

Mr. Hornbostel. Right. The Older Americans Act of 1987 amendments tried to clarify that a bit to specify that we are all part of the same office. And we are developing policies and procedures that govern our working position but the goal has always been to allow some local autonomy for each of the programs and each program operates in a bit different fashion.

Senator METZENBAUM. Who provides the money for the sponsoring agency?

Mr. HORNBOSTEL. Again, the money comes from a variety of different sources, Senator Metzenbaum. About 40 percent of the funding—somewhere between 40 and 50 percent of the funding comes from the Federal Older Americans Act. Other funding comes from a small pot of State money for working in adult care facilities. Some comes from church groups, private organizations, donations, and that sort of thing.

Senator METZENBAUM. Please proceed.

Mr. HORNBOSTEL. Okay.

Senator METZENBAUM. Thank you.

Mr. HORNBOSTEL. The concerns that I bring to this Committee are formed by the complaint work that our Ombudsmen in Ohio currently does.

Last year, the Ombudsman program in Ohio handled over 8,800 complaints. Of those 8,800 complaints, the majority are about nursing home care. However, we also handle complaints about public agencies. We handle complaints, obviously, about hospital discharge, complaints as you just heard. We handle complaints about no-care facilities which provide a lesser level of care than nursing homes do.

My remarks to you today are also formed by the fact that I am on the Steering Committee of the State of Ohio that is charged with implementing the mandates of the Ombudsman Budget Reconciliation Act of 1987, hereinafter called OBRA, and you indicated before that that is part of the alphabet soup that we unfortunately have to deal with.

And then the other hat I wear is that, like Mary Halfacre, my colleague, I am on the Board of Directors for the National Coalition of Citizens for Nursing Home Reform.

The witnesses you heard on the first panel today basically present a picture of long-term care problems that go far beyond Ohio's orders, problems that nursing home residents unfortunately face throughout the United States.

Ohio's experience in long-term care is, however, I think, useful in looking towards some of the solutions. I basically want to focus my remarks on three particular areas and then, of course, I will be glad to answer any questions that you may have, Senator Metzenbaum.

The first area is that the National Coalition of Nursing Home Reform contained in OBRA 1987 will remain an empty promise unless Congress acts now.

As you very correctly pointed out, there are very important things contained in the nursing home reform provisions of OBRA 1987, things that would address many of the concerns that have been raised in our first panel this morning, things that—such as increased training for nurses aides, things such as increased enforcement options through the State so that a Clearview or Extended Care situation need not happen again. All of these things are in jeopardy, however, if OBRA 1987 is not going to be fulfilled, if it is weighed down by the very bureaucracy charged with carrying forward its mandates.

OBRA 1987 contains time frames and mandates for both the State and Federal Government. According to the legislation, states must implement the provisions of OBRA regardless of whether the Health Care Financing Administration meets the time frames established by the legislation.

As you pointed out earlier this morning, Senator Metzenbaum, 10 OBRA deadlines have come. Not one of those deadlines has been met by the Federal Government.

And so Ohio because it is required by the legislation will implement OBRA. We will do so based on our understanding of federal graph guidelines that constantly change. We will do so despite the great cost imposed by OBRA that we estimate to be $41 million to the State of Ohio alone during the next biennium.

We will do so despite the confusion that is automatically engendered when the State has to constantly revise its implementation due to the latest rumors someone heard from Washington. But we will do so knowing that it could be done differently and correctly in a way that extends the maximum benefits of this new law to nursing home residents it was designed to protect.

We will do so knowing that if all levels of government were working together in sync, the promise of OBRA 1987 can yet be fulfilled.

Senator, I implore you to act at the highest level of the new Department of Health and Human Services whose head you are being asked to confirm next week to influence him to ensure that this OBRA mandate is taken much more seriously than it has been thus far.

The second area that I would like to address is Ohio currently has no mechanism for enforcing nursing home laws short of closing the nursing home, forcing the relocation of residents. That should have been obvious from our first panel this morning that this is in fact the situation here in Ohio.

Once upon a time, actually in England in the 19th century, there was but one penalty for one convicted of a crime and that was hanging. In fact, there are recorded cases of persons being hanged for stealing a loaf of bread.

But as time went on, an interesting phenomena had developed. Juries, knowing the sentence they would be handing out, stopped convicting the thiefs at all.

Ohio in its current long-term care enforcement system continues to have to hang thiefs for stealing loaves of bread. The only enforcement remedy we have available to us currently for any nursing home violation is to terminate the nursing home participation in the Medicare/Medicaid program or to revoke its license.

This means that the facility must close and the residents of that facility must be transferred with the attending transfer trauma that you have heard about several times this morning.

The alternative lesser violations, no matter how serious or how numerous, are often overlooked simply because we do not want to close all substandard nursing homes in Ohio.

OBRA offers new promise to us, however, in that it requires that Ohio adopt intermediate sanctions short of closing facilities. The goal is to require nursing homes to correct all of its deficiencies while at the same time prevent the mass relocation of nursing home residents on short notice with the transfer trauma and loss of lives that inevitably occur.

These sanctions include temporary management for facilities that are temporarily in difficulty, the state steps in, has a temporary manager appointed who runs the facility to bring it up to standards and then the residents remain while the home is being brought up to standards.

It includes civil penalties, monetary fines for violations of licensure and certificational law. It involves banning new admissions to the facility until it corrects its current problems.

And finally, perhaps borrowing on an old Quaker idea of witness, it allows the state to place a survey team in the facility that monitors the facility until the deficiency is actually corrected.

While Ohio has been a progressive leader in areas such as nursing home resident rights, Medicaid reimbursement and the regulation of Medicaid discrimination, we lag far behind other states in adopting a workable enforcement system that does not require relocation of residents.

My third and final point is that the monopoly currently enjoyed by nursing homes in Ohio in the provision of long-term care contributes greatly to quality problems in the nursing home setting.

One of the major problems with Ohio's long-term care delivery system is the current imbalance that exists between institutional and community-based long-term care. Ohio ranks 47 among the states in state-only spending for community-based long-term care services. This means that—

Senator METZENBAUM. Excuse me.

Mr. HORNBOSTEL. Will be nonexistence in most parts of Ohio. An older person or younger person in search of long-term care is forced sometimes prematurely to enter a nursing home as that is the only setting in which the older person can receive the care he or she needs.

Senator METZENBAUM. What did you say? 47th?

Mr. HORNBOSTEL. 47th in state-only spending for community-based long-term care. There are 46 states in this country that spend more on in-home community-based care than does Ohio.

And that is one of the major reasons, Senator Metzenbaum, that—perhaps the major reason, why it seems that people are having a hard time identifying options and so forth and why people have testified today that they have had trouble as they have looked for alternatives. The reason they are having trouble is because Ohio does not currently provide those alternatives.

Senator METZENBAUM. In-home community-based care means exactly what?

Mr. HORNBOSTEL. Means long-term care services that are delivered in a person's own home or in a community setting that provides a lesser level of care and less expenditures than a nursing home. Either one of those.

Senator METZENBAUM. Have you discussed this matter with the state officials who would be—would have an interest?

Mr. HORNBOSTEL. Yes. In fact, one of the things we are doing, Senator Metzenbaum, is that the Governor for this state has announced a new initiative which he terms Elder Care which would begin to address, not totally address, but begin to address this imbalance.

He is calling for funding of community-based long-term care alternatives in the amount of approximately $100 million for the next biennium. So we are in the process of addressing—

Senator METZENBAUM. Out of present funds, without any new taxes?

Mr. HORNBOSTEL. There would be an increase in the tobacco tax that would fund the service at least initially.

Senator METZENBAUM. And without that there wouldn't be any money at all for this? All of the 46 other states already have it?

Mr. HORNBOSTEL. That is correct, Senator.

Senator METZENBAUM. I would say have the Governor discuss it with me.

Mr. HORNBOSTEL. Thank you very much. We think—we obviously feel that this initiative is very, very critical.

What is needed is the delivery system of long-term care that ensures that information on services and benefit programs is provided to consumers. We need a system that assures appropriate access to long-term care both in nursing homes and in the community.

Seven percent of Ohio's nursing home residents need absolutely no assistance in the activities of daily living. They could receive services in their own communities. We need a system that is coordinated to ensure that services are provided when and where needed. In short, we need a system where access is controlled by the needs of older persons, not by the service provider who has a service to sell, nor by a system that has only one answer for every human need.

Thank you very much for your kind attention, Senator Metzenbaum. I will be pleased to answer any further questions.

[The prepared statement of Mr. Hornbostel follows:]

TESTIMONY BEFORE THE SENATE LABOR AND HUMAN RESOURCES HEALTH SUBCOMMITTEE REGIONAL HEARING

COLUMBUS, OHIO FEBRUARY 25, 1989

My name is Roland Hornbostel. I am currently the State Long Term Care Ombudsman for the Ohio Department of Aging. Ohio's Long Term Care Ombudsman Program includes the professional staff and volunteers of twelve regional offices. The Ohio ombudsman program receives over 8000 complaints annually. While the largest category of complaints concerns the quality of care delivered by nursing homes, our program also investigates and resolves complaints filed by residents or their sponsors against public agencies, adult care facilities, and other medical providers. The concerns that I bring to this committee are based on the experiences of our regional offices and based on my own involvement in the Ohio ombudsman program for the last twelve years. My remarks to you today are informed also by two other hats I wear - as a member of the Steering Committee formed by Ohio to implement the provisions of OBRA '87 relating to nursing home reform and as a member of the Board of Directors of the National Citizens Coalition for Nursing Home Reform.

The witnesses you have heard today present a picture of nursing home problems that go far beyond Ohio's borders - problems that nursing home residents face throughout the nation. Ohio's experience in long term care is useful in informing the national perspective as we approach the

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twenty-first century. I will focus my remarks on three particular areas.

1. The national vision of nursing home reform contained in the Omnibus Budget Reconciliation Act of 1987 will remain an empty promise unless Congress acts now.

OBRA '87 is the most sweeping nursing home reform enacted in our nation's history. This piece of landmark legislation is a direct outgrowth of a national study by the prestigious Institute of Medicine of the National Academy of Sciences of nursing homes and nursing home regulations. The study lasted over two years and produced a report that serves as the blueprint for OBRA '87.

The legislation itself was the product of an unprecedented consensus of over fifty national organizations including provider, consumer, and professional groups. The federal legislation is a clear reflection of the "state of the art" in our understanding of nursing homes and how nursing homes should be regulated. OBRA '87 contains clear mandates for nursing homes, for the states individually, and for the Department of Health and Human Services on a federal level (especially for the Health Care Financing Administration which is the arm of HHS responsible for the administration of the Medicare and Medicaid programs).

Unfortunately, the promise of OBRA '87 is in danger of going largely unfulfilled, weighed down by the very bureaucracy charged with carrying forward its mandates. OBRA '87 contains

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timeframes and mandates to both the states and the federal bureaucracy. According to the legislation, states must implement the provisions of OBRA regardless of whether HCFA has met the timeframes established in the legislation for the issuance of federal guidelines. Thus far since the passage of the legislation eight federal deadlines have come and gone. HCFA has not met a single one of the eight deadlines. Yet Ohio is required to implement OBRA's provisions despite the passage of the federal deadlines.

And so, Ohio will implement OBRA. We will do so based on our understanding of federal draft guidelines that are constantly changed. We will do so despite the great cost imposed by OBRA which we estimate to be 41 million dollars for the biennium. We will do so despite the confusion that is automatically engendered when the state has to constantly revise its implementation due to the latest rumor someone heard from Washington. But we will do so knowing that it could be done differently and correctly in a way that extends the maximum benefits of the new law to the nursing home residents it was designed to protect. We will do so knowing that if all levels of government were working together in synch, the promise of OBRA '87 can yet be fulfilled.

Congress should intervene at the highest level of the new administration to ensure that its directives are carried out.

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2. Ohio currently has no mechanism for the enforcement of nursing home laws short of closing the nursing home, forcing the relocation of its residents.

Once upon a time (actually in England in the 19th century) there was but one penalty for those convicted of a crime - hanging. In fact there are reported cases of persons being hanged for stealing a loaf of bread. But as time went on, an interesting phenomenon developed. Juries, knowing of the harsh sentences that would be handed down, stopped convicting the thieves at all!

Ohio in its current enforcement system continues to "hang thieves for stealing loaves of bread." The only enforcement remedy open to us currently for violation of nursing home regulations is to terminate the nursing home's participation in the Medicare or Medicaid program. Most often invocation of this penalty by the state results in the closure of the nursing home as 2/3 of Ohio's nursing home population are recipients of Medicaid. Given the fact that Ohio like most states carefully regulates the nursing home bed supply, Ohio can only close those facilities with life-threatening violations. The alternative: lesser violations, no matter how serious or how numerous, must often be overlooked.

OBRA '87 offers new promise, however, in that it requires that Ohio adopt intermediate sanctions. The goal of intermediate sanctions is to require nursing homes to correct all deficiencies while at the same time preventing the mass relocation of nursing home residents on short notice with the transfer trauma and loss of life that inevitably occur. These sanctions include temporary management for situations such as Toledo Extended Care or Clearview where the facility remains operational and deficiencies are corrected or sufficient time is allowed to do proper relocation of residents should that become necessary. Another sanction is denial of payments under Medicaid for new admissions to the nursing home. This allows a facility that has over extended itself to make corrections before new residents are admitted. A third intermediate sanction is civil monetary penalties for infractions of the regulations. Such civil penalties ensure that nursing homes have an incentive, albeit a negative one, for making prompt corrections of deficiencies rather than simply letting the deficiencies continue because the facility knows the state is helpless to force correction.

Another provision of OBRA requires the state to place monitors in nursing homes that are chronically out of compliance with the regulations until the deficiencies are corrected. I suppose this borrows the old Quaker notion of "witness" - the theory being that if someone is looking over your shoulder, you will likely be shamed into making the correction. Intermediate sanctions as required by OBRA must be implemented by October 1, 1989. Ohio will have to make major changes in current nursing home law if this mandate is to be met. While Ohio has been a progressive leader in areas such as nursing home resident rights, Medicaid reimbursement, and the regulation of Medicaid discrimination, we lag far behind other states in adopting a workable enforcement system.

3. The monopoly currently enjoyed by nursing homes in Ohio in the provision of long term care contributes greatly to quality problems in the nursing home setting.

One of the major problems with Ohio's long term care delivery system is the current imbalance that exists between institutional long term care and community based long term care. Ohio ranks 47th among the states in state-only spending for community based long term care services. This means that alternatives to nursing home care are nonexistent in most parts of Ohio. An older person in search of long term care is forced, sometimes prematurely, to enter a nursing home as that is the only setting in which the older person can receive the care he or she needs.

One of the key components in any system of quality assurance - competition - is missing in Ohio's current long term care delivery system. We believe that by rectifying the imbalance in long term care services that the quality of both institutional long term care in nursing homes and the quality of community based long term care in a person's own home will remain high.

Development of a community based long term care system will also address the major problem faced by older persons and their families when the need for care arises - knowing how to

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access a system of care that is fragmented, confusing even to professionals, and all to often simply not available in sufficient supply to meet the increased demand. This demand for services will grow exponentially during the next decade and on into the first decades of the new century.

What is needed is a delivery system of long term care that ensures that information on services and benefit programs is provided to consumers. We need a system that ensures appropriate access to long term care both in nursing homes and in our community. We need a system that is coordinated to ensure that services are provided where and when needed. In short, we need a system where access is controlled by the needs of the older person not by the service provider who has a service to sell nor by a system that has only one answer for every human need.

Thank you very much for your kind attention to these remarks.

Senator **Metzenbaum**. I will have questions but I think I will hear from the other members of this panel first.

Mary Halfacre, the more I say to the witnesses to try to hold their remarks to five minutes, the more it is disregarded. [Laughter.]

I am going to be a little bit tougher. I will ask my staff, Mr. James Wagoner, to advise me when five minutes is up and I will give you a signal and then take a minute or two more to wind up.

Okay. Mary, happy to have you with us.

STATEMENT OF MARY HALFACRE, VICE PRESIDENT, NATIONAL COALITION OF CITIZENS FOR NURSING HOME REFORM, COLUMBUS, OH

Ms. **Halfacre**. Good morning, Senator. I am Mary Halfacre, and I am also the Vice-President of the Board of the National Citizen Coalition for Nursing Home Reform. I am also the President of the State of Ohio Association of Long-Term Care Ombudsman. In my profession I am also a registered nurse, licensed nurse.

The Coalition appreciates your attention to this issue today. I will summarize my written testimony.

Our organization is comprised of over 250 member groups throughout the country including several that are here in Ohio.

Since 1978, our clearing house has provided public education on nursing home issues. We also implement strategies for improving quality of care for residents in nursing facilities.

From 1984 to 1986, we worked with the Institute of Medicine Study. It will be called IOM, one of the acronyms, after this.

Our organization made a commitment to see that IOM's important recommendations did not grow dusty sitting on someones' office shelf. We organized a national campaign for quality care composed of over 50 national organizations to study the report. Various and numerous meetings were held at the national level.

By our intensive joint review with consumer groups, health care professionals, nursing home providers, unions and other concerned parties, we were able to develop consensus opinions or positions on 12 issues that the IOM addressed such as nursing, nurses aides training and social work services.

Our positions were presented to Congress and to HCFA in April of 1987. Although there were some understandable disagreements on approaches, we were able to help sustain support for legislation by all concerned parties.

In December of 1987, when Congress enacted the new Title C Nursing Home Reform and Social Security Act, we all felt that a victory had been achieved for American nursing home residents.

Organizations in the campaign for quality care have worked long and hard to accomplish workable solutions to help implement the law. We have recognized the substantial effort that devoted staff of HCFA has tried to interpret the law and have offered unified positions to the government on a regular basis over the last year.

Given the tremendous resources that organizations have used to help achieve careful, responsible, effective implementation of the law, we have continuing concerns about HCFA's unresponsiveness. We would be remiss if we did not alert Congress that the government is falling short in meeting the obligations and the challenges set forth in legislation.

This failure has resulted in confusion across the country bordering on chaos in some of the states for regulatory and for Medicaid agencies, nursing home providers and staff and also the residents.

You are hearing about some of Ohio's experiences today. States have been placed in an untenable position.

For example, HCFA is now placing an overwhelming burden on them to absorb a new set of unnecessary regulations by August the 1st which would conflict or fall short of OBRA requirements.

Our testimony sets forth many problems so that OBRA can help influence new government action and advance the reforms. HCFA has proceeded with its own agenda which consumes precious staff time.

In December of 1988 HCFA issued a state nursing home survey report. The huge documents which have been printed twice because of errors were extremely costly to the public. They did not reflect extensive recommendations made by consumer or provider organizations. We have found them to be virtually useless and potentially harmful and misleading.

Senator **Metzenbaum**. How many volumes was it?

Ms. **Halfacre**. There were three and they are about yea high [indicating]. One of the reasons why they found them misleading is because some of the information there is outdated, it is as old as a year and a half.

Some of these problems have been corrected. There is no indication of which ones have been corrected. It's misleading so that people, consumers would not be able to read the information, analyze it and actually determine whether or not a nursing home would be able to provide quality care.

The time spent on this work would have been more productive developing workable guidance for other important issues.

A second major diversion from OBRA is HCFA's February publication of the new requirements for nursing home service. The law does not call for the requirements until—

Senator **Metzenbaum**. Just take a couple of minutes.

Ms. **Halfacre**. HCFA's priorities are out of touch with realities with the problems of the State. I would just like to cite an example at this point, is that current applicants for screening—and I don't know if Roland did get into the preadmission screening—but it is really causing havoc in some areas. I have had several nursing homes call me. No one seems to know how to fill out the screening and what to do with the people who are going to be misplaced or have to leave the nursing home. It is very cloudy and hazy at this point.

Federal funds in 1989 announcing federal funds would be at jeopardy if they did not implement the peadmission screening. Most states, as I have said, has scrambled to comply with this. Now, HCFA's general counsel has reviewed its draft and guidelines and determined that many fundamental features such as who would be screened, who would do the screening, who would be allowed to stay, are still, you might say, in limbo.

In short, HCFA's rush to publish the final rules 21 months ahead of schedule has resulted in a product that only adds to implementation problems at OBRA. It conflicts with the law in the areas of social work, activities and dietary service. We already have some laws on the books that are more stringent than what is being reintroduced.

Medicaid discrimination practices which have been a felony since 1977 under another part of the social security act——

Senator METZENBAUM. All right. All of your statements are included in the record. I am going to have to move ahead so that the people as well as the owners of this facility are given adequate time.

Ms. HALFACRE. In conclusion, I would just like to say our organization has worked on nursing home issues for over 14 years. We appreciate the enormous task of HCFA and hard work of its staff, but we contend that the administration of this important law thus far is unacceptable and should be challenged.

We hope that congressional leaders concerned about quality of care will help convince the new Secretary and the new HCFA Administrator to put the agency on a different course. Thank you and your colleagues for your attention.

[The prepared statement of Ms. Halfacre follows:]

TESTIMONY OF

THE NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM

Before The U. S. Senate Committee

on Labor and Human Resources

February 25, 1989

Columbus, Ohio

Good Morning Senator Metzenbaum, my name is Mary Halfacre. I am a Vice-President of the Board of the National Citizens' Coalition for Nursing Home Reform. We appreciate your attention to this issue and the opportunity to testify. In Ohio I have served for over nine years as the long-term care ombudsman for District XI, Area Agency on Aging, in Youngstown. I am also an experienced, professional nurse.

Our organization is composed of over 250 member groups consisting of local and state ombudsman programs, citizen advocacy organizations, church groups, nursing home resident organizations as well as individual resident councils and even a few nursing home facilities. Through our national clearinghouse, established in 1978, we provide public education about nursing home issues. We also develop and implement strategies for improving the quality of life and care for our citizens who live in nursing homes. Part of this strategy is to work cooperatively and constructively for change with providers of care and state and regulatory officials. Another is to promote efforts which empower residents and their family members and representatives to actively participate in improvement activities.

We supported and worked with the staff and Committee of the Institute of Medicine study on nursing home regulation funded through a contract from the

Health Care Financing Administration of the Department of Health and Human Services. Congress instigated this study because of the proposed cutbacks in nursing home regulation in 1981. When the IoM issued its report, our organization made a commitment to see that the Committee's important recommendations for improvements in laws and regulations did not gather dust for lack of action. We immediately organized a national "Campaign for Quality Care," composed of over 50 national organizations to support and move the recommendations forward. Our approach was to study the report in work sessions with participation from consumer groups, health care professionals, nursing home providers, unions and other concerned parties. In our intensive joint review with at least twenty organizations, we were able to develop consensus positions on twelve of the issues that IoM addressed. (Included are residents' rights, ombudsman programs, equal access to quality care, resident assessment, nurse aide training, nursing, social work services, mental health, survey and certification, elimination of the distinction between ICF and SNF levels of care, medicaid payment and enforcement of laws and regulations.)

The consensus positions were presented to Congress and to the Health Care Financing Administration in April, 1987, with some positions reflecting endorsement from 60 organizations. Although there were some understandable disagreements on approaches to reform, we were able to help foster support for national legislation by all concerned parties, including the national provider organizations. In December, 1987, when Congress enacted a new Title C, Nursing Home Reform in the Social Security Act, we all felt a victory had been achieved for America's future nursing home residents.

Since organizations in the Campaign are quite aware of the many complicated, ground-breaking provisions in the law, we realized that our work had just begun. We turned our attention to participation in the regulatory activities of the Health Care Financing Administration. Another series of working sessions was initiated. Representatives from over 30 national organizations now meet together monthly to review and comment on various HCFA regulatory proposals relating to the law. Many more participate through mail and telephone correspondence. Additionally, small work groups which include representatives of all concerned parties meet to work out consensus language relating to nurse aide training and pre-admission screening to determine the need for services for mentally ill and mentally retarded, and other issues.

The organizations in the Campaign for Quality Care have worked exceedingly long and hard to accomplish workable solutions to complicated issues. We know that the law is comprehensive and complex, and we recognize the tremendous effort on the part of many devoted civil servants working at HCFA to interpret the law and develop guidance for the states. For these reasons, we have offered unified positions to the Health Care Financing Administration on a regular basis over the last year.

Given the tremendous resources that organizations have used to help achieve a careful, responsive and effective implementation of the law, we have continuing concerns about HCFA's unresponsiveness to our joint efforts. (Two of our letters offering assistance and our concerns to Secretary Otis R. Bowen and Administrator William Roper have been submitted for review.) HCFA's underutilization of this unique public participation, results in a waste of time and energy, as well as controversies which could be avoided.

Of most importance, we would be remiss if we did not alert Congress that the government is failing to meet the obligations and the challenges set forth in the law. This failure has resulted in confusion across the country, bordering on chaos in some of the states - for regulatory agencies, Medicaid agencies, nursing home providers and staff, and residents. You are hearing about some of the Ohio experience today.

States have been placed in an untenable position. HCFA is now placing an overwhelming burden on them to absorb a new set of unnecessary regulations, often conflicting or falling short of OBRA requirements. A bare minimum period of time to receive instructions or training is provided. States will be responsible for applying these new requirements to nursing homes on August 1, 1989, in anticipation that they can expect even more changes or different directions on the same issue shortly thereafter.

In this testimony, NCCNHR sets forth the many problems which have surfaced, so that Congress can help influence new government action to advance the reforms adopted as public policy. The beneficiaries of our combined efforts will be the residents who deserve and are entitled to quality care in nursing homes.

OBRA Implementation Dates Not Met by HCFA

Since OBRA '87's Nursing Home Reform Amendments were enacted, HCFA has missed ten deadlines for regulatory action:

(1) Use of federal authority for alternative enforcement mechanisms

(2) Standards for Nursing Home Administrators

(3) Specification of which items and services Medicaid will pay for and which can be charged to a resident's personal funds

(4) Requirements for nurse aide training and competency evaluation

(5) Guidelines to states to establish registries to record which nurse aides are trained, competent, and eligible to work in nursing homes and to receive, investigate and maintain records of employees found guilty of abuse, neglect or theft

(6) Procedures for appeal for residents who are about to be transferred

(7) Criteria for screening to determine which mentally ill or mentally retarded persons should be in nursing homes and which should be elsewhere

(8) Criteria for states to monitor waivers of licensed nursing requirements

(9) Requirements for states for use of their alternative enforcement powers

(10) Specification of assessment instruments and procedures used to determine residents' needs and plan their care.

HCFA Proceeds with an Irrational Agenda; Unresponsive to Public Need

In the meantime, HCFA has proceeded with its own agenda of activities which have consumed considerable, questionable staff time and energy: Release of Summaries of Survey Data (December, 1988) and publication of "Long Term Care Facility Requirements" (February 2, 1989).

From February 1988 until December 1988, HCFA diverted major staff resources to the development and publication of a compilation of nursing home survey reports from each state. Over 75 volumes were released in large quantities to the media and the states. The reports did not reflect extensive recommendations made by consumer or provider organizations which were asked to review draft materials "so that the resulting products would be most helpful to consumers." The voluminous reports, which had to be printed twice because of errors, were extremely costly to the public . In NCCNHR's opinion, the reports are virtually useless and potentially harmful because of misleading, missing and sometimes inaccurate information. The time spent on this work would have been more productively spent in developing workable guidance on important issues in OBRA, advice offered by NCCNHR and other organizations when HCFA presented this project idea.

A second major diversion from work on OBRA has resulted from HCFA's publication of "Requirements" this month. The Nursing Home Reform law does not call for issuance of the Requirements (formerly called Conditions of Participation) until October 1, 1990. Besides the work on the requirements over the last year, HCFA is now diverting a number of staff to work on the interpretative guidelines relating to the requirements. By issuing these new requirements now, HCFA places yet another burden on states already overwhelmed trying to meet their other obligations without federal guidance.

HCFA's priorities are out of touch with the reality of what states are facing with OBRA. Publication of the new requirements is the first phase in HCFA's plan for implementation. The plan calls for publication of a proposed rule later in 1989 to address nurse aide training, pre-admission screening for the mentally ill and the mentally retarded, requirements for administrator licensure, appeal rights for residents being transferred, use of restraints and psychotropic medications, and delineation of which items and services Medicaid will pay for and which items and services nursing homes can charge to residents' personal accounts. None of these plans for proposed rules in the spring will address substantive problems with the Requirements published in Feburary. A second proposed rule is also scheduled for publication later in the year on survey and enforcement procedures.

Due to deadlines imposed by the 1987 Nursing Home Reform Amendments, states are already grappling with some of these issues. OBRA directs the states to begin implementation of nurse aide training and pre-admission screening programs as of January 1, 1989, with or without federal guidance which was not given. HCFA has been working on this guidance (designated as "issuances" for the state operations manual) for several months, claiming on a month-to-month basis that they would be ready for state use. They are still in draft form. Now HCFA plans to publish proposed regulations on these issues "sometime in the first half of 1989." Final regulations are not expected before well into 1990, almost two years after states will have been responsible for proceeding with them.

One example of the problems this creates is that current nursing home employees will have their jobs on the line if they are not able to demonstrate their competency between July 1 and [illegible] 1989, yet HCFA will not have guidance available to the states on how [illegible]s must demonstrate their competency until sometime in 1990.

A second example is that current applicants for admission to nursing homes must be screened now to determine if they are mentally ill or mentally retarded and if so, whether they need nursing home care and whether they need active treatment. HCFA sent draft guidance to the states in October and sent a notice to states and to nursing homes in December, 1988 and January, 1989 stating that it would require them to forfeit federal funds if they did not implement the pre-admission screening. Most states scrambled to be in compliance. Now HCFA's General Counsel has reviewed its draft guidelines and determined that many fundamental features of the guidelines, such as who should be screened and who can stay/who cannot stay in a nursing home, must be changed because they way they were originally drafted violates the law. In the meantime states and nursing homes have proceeded according to the old draft. HCFA does not expect to provide new instructions for a few more months and these also will be "preliminary" and "advisory" and "subject to change."

The rush to publish a final rules on nursing home requirements this Feburary - 21 months ahead of schedule has resulted in a product that only adds to the implementation problems of OBRA.

Additionally, we have noted the following problems with the new rule:

* It merely parrots the law in many places where interpretation is seriously needed. For example: How must a facility assure that all its residents "attain or maintain the highest practicable physical, mental and psychosocial well-being? Given the "outcome oriented approach of the regulations, how much harm must a resident endure before a facility is required to have the capacity to meet a residents' needs? What rehabilitative services need to be provided on what basis to residents? How do you adequately prepare a resident for transfer? How should a facility provide for residents if it has a waiver of its licensed nurse staffing requirements? What is an acceptable program of social work services or activities? The list could go on and on.

* The rules address nursing homes' responsibilities related to nurse aide training and pre-admission screening for the mentally ill and mentally retarded are minimal and insufficient, yet as stated before, states are implementing these programs as of January 1, 1989 without any federal guidance. For example, the regulations do not explain how a facility must meet the mental health needs of its residents, how it must prepare residents

for a safe and orderly transfer, what kind of in-service training it should provide for nurse aides, whether and to what extent aides who are in training may care for residents.

* It specifically contradicts the law in the areas of Social Work Services, Activities and Dietary Services. Amendments to OBRA in the Catastrophic bill prohibit HCFA from issuing requirements less stringent than current rules. HCFA deletes language explaining how these services are supposed to care for residents and would allow unqualified staff to direct these services. In this way it actually represents a step backwards in the requirements.

* Many of the residents' rights provisions currently in effect are repeated in these new rules, though some current provisions are omitted. Some of the advances of OBRA are delayed until 1990, such as immediate access to residents by their families and some of the protections relating to resident transfer. Medicaid Discrimination practices which have been a felony since 1977 under another part of the Social Security Act are labelled in these regulations as not effective until 10/1/90. HCFA offers no interpretation of the requirement that facilities provide identical services to residents regardless of source of payment, an area in which there has been little regulatory experience. On a positive note, provisions related to bed-hold are effective 180 days after publication.

* HCFA calls these "final rules with request for comment" yet it states that it plans to implement the rules as they are published offering only the possibility that it will incorporate some changes into a new version of the rules that may be published sometime in 1990 or thereafter. HCFA therefore shuts out any meaningful comment on its interpretation of OBRA, which is unnecessary since the regulations are not required for another 19 months.

* If indeed HCFA does make any adjustments based on public comment (and officials have stated their hopes for very few adjustments), it sets up a situation in which states, nursing homes and the public may be forced to absorb two changes in these requirements within 2 years, in the midst of trying to implement all the other OBRA provisions without the benefit of HCFA guidance until after the fact.

* In the meantime, in areas where HCFA regulatory work contradicts the law such as activities, dietary and social work services, if implemented as directed, the states would operate in violation of the law for at least a year.

* In other challenges to regulatory process, Courts have ruled against HCFA determining that "final rules with comments" violate the Administrative Procedures Act because they are neither final rules nor are they a sincere attempt to receive comments.

* HCFA is also violating the OBRA provision which exempts regulations on OBRA from review by OMB. Not only were these regulations reviewed by OMB, but also it was OMB which specifically made some of the changes which downgrade dietary and social services.

* HCFA has established an implementation timetable on these regulations which gives them until July 1 to complete the process of developing interpretative guidelines and until August 1 to complete a process of training 3000 surveyors across the country on how to use this new system. Under this time frame it will not have the time to receive public comments on the interpretative guidelines, which may serve as the only forum for discussion of what OBRA provisions mean. It does not have the resources or the personnel to train

3000 surveyors adequately, yet those surveyors will be on the line interpreting the new requirements and enforcing them August 1, 1989.

* Many of the final rules will become effective August 1, 1989, 180 days after publication. In a number of instances, HCFA determined that because of specific dates in the 1987 Nursing Home Reform Amendments, it must wait to implement portions of the regulations until 10/1/90 or whatever other date is specified by the law. The variety of implementation dates adds even more confusion for the states and providers of care.

* An additional, major complication is that OBRA requires substantial changes in the way nursing home deficiencies are determined and the regulations are enforced (the survey system). HCFA has barely begun the development of this portion of the regulations although OBRA's enforcement provisions were effective January 1, 1988.

Conclusion

Our organization has worked on nursing home issues for over fourteen years. We know the public has waited a long time for needed legislative and regulatory reforms that will result in quality care for residents. Still, we know that it will take several years to accomplish all of the goals adopted by Congress. We are certain that the public expects all of us to meet this challenge through a well-organized, timely and realistic approach.

Although we fully appreciate the enormity of the task before HCFA and the hard work of its staff, NCCNHR contends that HCFA's administration of this important law, thus far, is unacceptable and should be challenged. We are hopeful that Congressional leaders concerned about quality care will help convince the new Secretary and a new HCFA Administrator to put the agency on a different course. Given the complexity and scope of the law, we know that a broad-based, consensus building approach is essential if nursing home residents are to eventually benefit.

Thank you and your colleagues again for your attention and leadership.

Senator METZENBAUM. Thank you.

Mr. Woody, we are ready to hear from you.

STATEMENT OF CONRAD C. WOODY, MEMBER OF THE BOARD OF DIRECTORS ON BLACK AGING AND DIRECTOR OF THE HUMAN SERVICE DEPARTMENT OF THE CMACAO, COLUMBUS, OH

Mr. WOODY. My name is Conrad C. Woody. I am a member of the Board of Directors on Black Aging and Director of the Human Service Department of the Columbus Metropolitan Area Community Action Organization.

The elderly population is truly one of our greatest assets. Seniors provide a reservoir of information about our past as well as substantive solutions to current problems that are faced by our society. By example, they showed determination, resolve and commitment. Sacrifice is redefined with the emphasis on eventual outcome. Hard work is not unusual but expected and accepted as a means to work, family and community goals. Disappointments are perceived as true learning experiences from which they move on to other strategies to meet their needs. This is really a segment of our population who has given much and asks for little.

For thousands of older Ohioans, the golden years of good times and reciprocating support from their families and communities are an illusion and sometimes fail to materialize at all.

Through family neglect and poorly-funded community support systems and inadequate personal resources this segment of the elderly population continues to deteriorate before our very eyes. The time to rethink our commitment and resolve towards the elderly population is much overdue. Each of us must analyze our own personal commitment toward our own aging families and the elderly in our own communities.

Are things going as well for our aging relatives as we would like them to go? Since the elder are rarely accused of being complainers, it would take more than infrequent visits or quick telephone calls to assess their real ability in maintaining their independent living environments.

The informal support network, including family care giving, cannot be underestimated or overlooked in determining its value to the elderly. We must also look closely at the network of services available to the elderly.

The Older American Act provides a framework from which countless services are provided to seniors throughout this country. Homemaker, health, transportation, legal, friendly visitors, telephone reassurance calls and nutrition services keep many older persons where they want to be in their homes and communities. However, equitable treatment for minorities has not been an accomplishment under this federal legislation.

In fact, the minorities participation rate in Title 3-B Supportive Services and Senior Citizen Programs has declined by 24.7 percent during this decade from a high of 21.9 percent in fiscal year 1980 to a low of 16.5 percent in 1985.

The aged black participation rate for the elderly nutrition program has declined by 9.8 percent during this decade from 12 percent in 1980 to 10.1 percent in 1985.

To reverse this downward trend for aged minority participation in the Older Americans Act Program, recent amendments have stated clearly and definitely that older majorities are a target group to whom these services are to be provided. However, whether we consider the service from the Social Service Block Grant, the Community Service Block Grant, the Older Americans Act or another system which provides significant funding and support to the elderly, all programs must work cooperatively and be created and fluent in their design to provide the maximum support to those seniors who need the service the most. Governor Celeste's Elder Care Initiative is an excellent example of leadership in providing service to seniors when and where they need them the most. Not only does this initiative bolster in-house community-based service but it does it in a way that the older person truly has a greater choice in selecting from a menu of services that represent an extensive range of preventive and supportive services.

The Governor's Elder Care Initiative Act readily assesses where we are now and boldly addresses where we want to be in the future. To take away a number of myths such as elderly are living better than the rest of our population or poverty is not a serious problem anymore, about two years ago the National Caucus on Center for Black Aged launched a comprehensive study with the House, with the Congressional Black Caucus.

In 10 major cities, various testimonies reaffirmed the fact that aged blacks are the poorest of the poor among the elderly and they are at the bottom rung of the economic ladder for all groups in our society.

NCBA's number one priority is the abolition of poverty for all older Americans, whether they are black, white, hispanic, spanish, native American or any other ethnic group.

Inadequate income and retirement is the number one problem for older blacks and is the true cause for virtually every major dilemma affecting them, whether it is unfit housing and inappropriate diet, poor health or other living conditions.

For these reasons, NCBA, supported by many other national aging organizations, urges the Federal Government to commit itself to establishing the official poverty level as the benchmark for the minimum payment of supplemental security income, benefits to low income aged persons.

In NCBA's judgment, this would do more to help low income older Americans than anything else because an adequate income and retirement is the paramount concern for the aged black and other low income elderly persons.

SSI is the most cost effective means to come to grips with wrenching problems because it is targeted to the person. In consideration for the current budget deficit, this approach may require a phase-in period to produce the desired results, but it is imperative that this initiative is advanced as quickly as possible.

Let's begin to treat our elderly citizens with the care and concern that they deserve. Personal commitment, quality programs, new and innovative Elder Care Initiatives, SSI reform, and providing a road map for success. Thank you, Senator.

Senator METZENBAUM. Thank you, Mr. Woody.

I might say that the complete statement of each of you will be included in the record.

Mr. Hornbostel, if you had one recommendation to make--I will give you two: One in Congress and one to the State of Ohio, what would you recommend?

Mr. HORNBOSTEL. For Congress, what I would recommend is that especially the Senate, which is right now in the process of confirming a new Secretary of Health and Human Service, ensure that through this confirmation process it is made clear that the mandate that Congress passed over a year ago was a very serious mandate from Congress, given a lot of thought over a number of years and that you intend that it be carried out.

As a mandate for the State of Ohio, I think we have a duty to do the best we can. And as member of the Steering Committee, we will do the best we can, given the lack of federal support in implementing OBRA, we will do our best.

But I think that the big thing that we need to do in this State is that we must provide people with options and choices in regard to long-term care that do not now exist, and that is why this Elder Care Initiative that Mr. Woody and I have both talked about is very, very important.

Senator METZENBAUM. Do you feel that the State ought to threaten, even if not totally implement, but threaten more nursing home operators with loss of license?

Mr. HORNBOSTEL. Senator Metzenbaum, I believe there is a more effective way to enforce standards than to threaten a home with loss of its license. If a home loses its licenses, the residents must be moved. Over and over again today we have heard about the very traumatic human costs in terms of the number of deaths from Extended Care in Toledo that happens when a state pursues that policy.

What the state must do is adopt intermediate sanctions that give us teeth in the law to force nursing homes to correct deficiencies but do not result in transfer of residents.

Senator METZENBAUM. I think the State has the legal right to do that.

Mr. HORNBOSTEL. I believe that OBRA '87 gives us not only the legal right but the clear mandate that we must do it or the State of Ohio will face the loss of future Medicaid funding to the State if we do not.

Senator METZENBAUM. Thank you. Ms. Halfacre, first let me just ask you how is the National Coalition funded?

Ms. HALFACRE. How is it funded? There are various--I am not certain. I know they recently received a grant from--a national grant that they are working in cooperation with the Administration on Aging to do some pilot projects, and that's part of the funding. I think they receive funding from Villers, other funding from--where is--

Mr. HORNBOSTEL. Senator Metzenbaum, I am the former treasurer of the organization so I know specifically where it comes from.

The money comes from private foundations such as the Viller Foundation. It comes from the American Association of Retired Persons, and it comes from its more than 300 member groups that pay dues into the organization.

Senator Metzenbaum. No funding from any place where there would be a conflict of interest?

Mr. Hornbostel. We do not believe that a conflict of interest exists with any of the funding. We have been offered funds in the past by organizations that represent nursing homes. However, we have turned those funding sources down.

Senator Metzenbaum. Thank you. Ms. Halfacre, if you could have one wish fulfilled either by the State, Federal Government or whatever, what would it be?

Ms. Halfacre. My one wish would be to make certain that all nursing home residents or their families know that residents rights are conditional participation so that when they have problems such as the person from Toledo, they know where to go, the young ladies who didn't know there was an agency with people out there that would assist their brother when he was having problems. And part of that, I think, is also the nurses aide training. I think the two are paramount.

Senator Metzenbaum. What would you think of requiring all nursing homes to have in them names of the telephone number, addresses of the Ombudsman?

Ms. Halfacre. They do.

Senator Metzenbaum. Okay.

Ms. Halfacre. I don't know whether the Ombudsman programs have to make themselves more visible in specific areas.

Senator Metzenbaum. Mr. Woody, some of your testimony was directed at the question of poverty itself, and I think we share that concern.

I have a YES Act, Youth Employment Service Act. I have other participation with respect to the matter of bringing up the poverty level in this country.

But I think we have to separate that from the concern with respect to the nursing home patients for no other reason than the other problem—this problem is tough enough. The other problem is so much greater in its challenge.

And I am wondering what suggestions, what one suggestion you might have as to what can be done to help alleviate the problem.

Mr. Woody. Senator, the SSI reform that I alluded in my testimony, it is important not only for black older Americans but for all older Americans who have very little income.

But I think what is needed is options, options for senior citizens so that they don't necessarily find themselves in need to go into nursing homes.

Seniors want to remain in their homes, and the Governor's Elder Care Initiative, if you supported that fully, and other people supported that, and he could get the funding for that program, would provide many seniors with those options that would prevent a lot of them from going into nursing homes.

Senator Metzenbaum. Mr. Woody, I support the Elder Care concept. This Senator is very sensitive about new taxes that are levied upon the middle class, poor Americans. And I can tell you I have some concerns because talking about regressive tax, tobacco tax, gas taxes, I face this issue regularly and I work closely with the Governor. He is a good friend.

But I am frank to say that funding it with tobacco taxes is a concern, funding it with gasoline taxes, funding with people oriented taxes. It is a tax called—at the federal level VAT, Value Added Tax, all directed at ordinary people, and those that are best available to pay don't pay their fair share.

Does that give you any concern as far as you are concerned?

Mr. **WOODY**. Yes. It gives me a concern, and I think the Governor is sensitive enough and realizes a need for this initiative that maybe he is not firmly set this is the only way that this Initiative can be funded. If there could be another way that equitably distributes the income that would be needed to support these programs I think he would support that.

Senator **METZENBAUM**. Thank you very much. You have been very helpful.

The next panel member is Tom Gault, the President of the Ohio Health Care Association and Administrator of Harrison House in Cincinnati, and Larry Harris, the President of the Ohio Association of Philanthropic Homes for the Aging, and Administrator of Willow Brook Christian Home in Columbus, Ohio.

Mr. Gault, we will hear from you.

STATEMENT OF TOM GAULT, PRESIDENT OF THE OHIO HEALTH CARE ASSOCIATION AND ADMINISTRATOR OF HARRISON HOUSE IN CINCINNATI, OH

Mr. **GAULT**. Thank you, Senator. It is a privilege to be here today. One minor correction. I am not a licensed nursing home administrator. I would not like the Administrators' Board to hear that too loudly so we certainly want to correct the record on that.

I am a Certified Public Accountant. I am here today as the owner of Harrison House Nursing Home in Cincinnati, OH. It is a 101-bed skilled intermediate care facility.

I am also here today representing the Ohio Health Care Association which is an association of over 400 proprietors not-for-profit and mentally retarded facilities throughout the State of Ohio.

I am very pleased today to have this opportunity and to participate in this forum. It is stimulating and prior testimony, no doubt, has been heartbreaking to us to some extent as we hear the plight and problems that involve the members of this industry. I have—

Senator **METZENBAUM**. Let me just interrupt you. My notes say you are speaking for the for-profits. You are saying you speak for the non-profit institutes?

Mr. **GAULT**. Our association has got for-profits and not-for-profits, mention both. Primarily we are primarily the proprietary for-profit organization.

Senator **METZENBAUM**. I'm sorry. You go ahead.

Mr. **GAULT**. We have presented written remarks. Now I will attempt to my very best to abbreviate them and concentrate on some of the major issues.

Senator **METZENBAUM**. Thank you.

Mr. **GAULT**. There are 90,000 residents in nursing homes in Ohio, and we agree that they have the absolute right to quality care life and we support that totally.

No doubt we have heard of instances in Ohio where there are problems. We suggest that a part of those problems clearly can deal and be dealt with from the standpoint of funding and inadequate funding in many respects.

In spite of the fact that we want to talk about the quality of care, we cannot escape the correlation between quality and cost. And to that extent, it's important to remember that a funding program that gives the operator an opportunity to remain stable in terms of the financial constraints so that they can concentrate more on the ability to deliver the kinds of care I think is an appropriate situation.

The positive side I think is that in Ohio, the Ohio Medicaid system over 10 years ago developed a reimbursement system that we feel did the job. It had as its purpose a number of goals, one of which was to give an incentive to the nursing homeowners and operators to provide care; two, to provide effective cost containment and control; three, to provide for access; and, four, to add stability.

Now, we have heard instances, I think, today where maybe that hasn't been accomplished totally in Ohio, but I will suggest that in Ohio we have done a much better job by virtue of that formula.

I think we know that there are problems within that reimbursement system that hasn't been addressed in the last ten years. We have today terms, if you will, of sub-acute or super-skilled patients, and we have some problems in our current reimbursement system that need to be enhanced and improved so that it gives a better opportunity for the providers to provide the kind of care necessary.

Senator **Metzenbaum**. Tom, address yourself, while you are on this point, to, why some nursing homes with the same amount of income do such a terrible job and some homes with the same amount of income do an excellent job. We hear people going from one home to another and we heard two witnesses say they went from this home to the next home and it is so much better, and they said the home in Cincinnati is horrendous.

As I said to Mr. Woody, when he was testifying, there's a general concern about poverty in the black community of America, but what I don't understand is why two nursing homes both getting approximately the same amount of dollars per patient, per resident, one does a great job, one does a horrible job. That's what concerns us.

Mr. **Gault**. Senator Metzenbaum, I think that concerns us as much because we want those homes that are substandard to be improved. I think that we go through from our Association standpoint many programs of education trying to help administrators, directors of nursing facilities, plant people of all kinds to come up to standards.

Senator **Metzenbaum**. How many nursing homes do you have in your organization?

Mr. **Gault**. In our organization, over 400.

Senator **Metzenbaum**. Do you have any person or persons that has the authority to move around the State, walk in a nursing home, say, "This place smells, this place is dirty, this place has got towels around, this place has got people strapped to their chairs?" Do you have any—and say, "You are going to either shape up on this or we are going to go against your license?"

I think many professionals, the Bar Association, the medical profession, the accounting profession, other professions, you have a certain amount of self-policing that does provide better professional services.

Does your organization have such a setup?

Mr. GAULT. Yes, Senator, we do. The Ohio Health Care Association for nearly the last decade has pursued and pushed and advocated quality of care and they have done it in two forms, one of which is a—what we call a peer review program. And applicants for membership in our Association are required to submit themselves to a review program by peers, members of our Association. And they do walk through the facility and we have on occasions clearly not admitted facilities to our membership.

Now, that's not a perfect solution. That's only a beginning because it is only on admission. And we have the same difficulty that you would in terms of what happened to that facility after they have been accepted, and we do not have a provision whereby we can really go in and police them or monitor them.

Senator METZENBAUM. Yes, you do.

Mr. GAULT. We haven't done it.

Senator METZENBAUM. Let me just say to you, I believe that the worst situation in this country comes about by way of the fact that those who are in a position to do something about the problem don't do it.

And—as a consequence, what you have is the government coming in, and we never go a little way, we go all of the way. The pendulum swings all of the way.

I remember when one of the medical disciplines was having some major problems in Ohio a few years ago, and I called them in and I said, "Either you get your house straightend up or I am going to offer some legislation that will deal with this particular discipline in its entirety." They went in to do something about it.

I want to state to you, Mr. Gault, that I think the business you are in, operating nursing homes, is a fine business. There is no reason for anybody to not appreciate what you are doing nor not to recognize the challenge.

But I would say to you that your organization would save itself untold misery if, when you hear of a bad place, you went in and you said that you are going to publicly disassociate, you are going to publicly suspend them from membership.

You heard this lady speak this morning about a place down in Cincinnati. She will tell you. I think if you send two people or three people in, walked in, not called them in advance and tell them you are coming, but just walked in on them and, boom, said to them, "Either you shape up or we are going to publicly disavow our relationship with you," I think many of us would feel so much better.

I don't want to be the police. I don't want to find out ways to be tougher. And—if I did nothing else in this hearing, I would like to send a message to your organization to say, look, you are big business, 400 homes. I don't know what the total gross volume dollars would be, but it is big.

Take a certain amount of that, train one, two, three, four people as a self-policing mechanism, and I will guarantee you Congress will look more favorably on you by reason of that fact.

Now, what happened, we hear some horror stories and we want to beat all of your brains out and some of the best facilities get taken in with some of the worse. Enough said. Speech. [Laughter.]

Mr. GAULT. I am not sure if those homes are members or not, by the way. [Laughter.]

Senator METZENBAUM. Even if they are not, move in, do something about it, and we will help you at all levels of government.

Mr. GAULT. Senator, I assure you that I will take the challenge back to my board and to the membership in our community of nursing home owners, managers and administrators; believe me, I will.

Senator METZENBAUM. I have taken most of your time. If you want a few more minutes, go ahead.

Mr. GAULT. Yes. We are going to jump around because we will have to pass up a lot of points recognizing the time restraint.

I would like to talk, I guess, about consumer protection and some of the issues as far as we have heard today.

And I think there are a number of ways that the consumer can begin to evaluate the quality of care in the nursing home. I would like to discuss probably for about three hours with you how we define "quality of care." Unfortunately, we don't have the time to do that today.

I would suggest to you, though, in the form of a question, is the quality of nursing the ability to deliver the service on time? Or is the quality of nursing the ability to have the time to care? And are we able to pay or willing to pay for that extra time?

And I think that's one of the problems that we regularly face. You know, we see a funding mechanism in Ohio for 10 years. In the last year we have seen cuts in those payments. That makes operators nervous in terms of going forward to make additional expenditures.

Senator METZENBAUM. We have also seen during that period a rise in the number of national corporations making very good money in the nursing home business.

I am not opposed to the profit motive. I am perfectly happy to see nursing homes make a profit provided that at the same time they provide the care for the patient. Unfortunately, there is no unanimity in this area. Some make the profit and do a great job. Some make a profit and do a horrible job. And so I think if you want to keep making a profit, the best thing you can do is provide the most policing of your own industry.

Mr. GAULT. I don't disagree with that. I would say, though, that are—there are some companies that are not making money, but I don't want to debate you on that issue.

I would like to at least make a couple more comments with respect to the consumer protection.

You know, we have heard one incident this morning of one individual who spent three months searching for nursing homes. I have to applaud that lady because the first—I think the primary need for people and consumers is to evaluate the nursing home.

And what we hope most people will do first is simply to get out firsthand and take a personal visit to the nursing home.

We can provide you with booklets. They are available in many areas. We have a booklet we call "The Emotional Decision" that we make available free to the public. We even had a 1-800 line number to try to advertise that brochure.

In that brochure there is a check list that we encourage people to take with them to try to evaluate. I think we need from a consumer standpoint to know that we have to continue day in and day out to pay attention to that.

Just as a survey from HCFA may identify a facility is doing a good job today, that doesn't mean the facility is doing a good job tomorrow, and we know that things change. So I think we want to just simply stress the fact that the most important part of that consumer protection is that firsthand care and involvement.

Most facilities in Ohio will provide House Bill 600 which is a bill of rights that's been around in Ohio for many, many years that will identify to potential residents what their rights and patients rights are. And I think we have to encourage that.

Certainly, we have already talked about our peer review program. There has been discussion about the HCFA guide and I will pass on that. I guess the other thing I would like to address briefly, if I could, and that would be that we, too, support the Elder Care Initiative that we are hearing about because we see the demographic and aging—and I will not repeat those for you today—but we know there is going to be a need for more nursing homes, not less, and at the same time there will be a need for a lot more services to a lot more growing population.

We will have in the nursing home environment all we can do to serve the over-85 population that's going to grow in a fantastic rate. At the same time, community-based services are going to be important.

I think that we can be a part of those services, and I think the nursing home can in fact become the hub wherein many, many of those services are offered to the community and I think that that would help immensely.

But when we talk about these added community services I have to be concerned from the standpoint of we are bringing in a whole new group of citizens into a possible arena that we are going to have to fund. And I am concerned about our ability to fund not only the nursing home program but that community care program as well, and that's going to create, I think, major challenges on you and I from the federal and the state perspective as well from the individual proprietor.

Senator **Metzenbaum**. Thank you very much, Mr. Gault. I am very pleased to say we are very pleased to have you testify. I do hear good reports about your facility.

And I am very serious about this question of 400 operating nursing homes providing some oversight of their own industry, and I will probably be writing to you in that connection so you won't forget our conversation here today.

Mr. **Gault**. Very good.

[The prepared statement of Mr. Gault follows:]

TESTIMONY BEFORE

SENATE SUBCOMMITTEE ON AGING

CHAIRED BY SENATOR HOWARD METZENBAUM

ON

NURSING HOME CONDITIONS PROTECTING THE CONSUMER

BY

THOMAS E. GAULT, PRESIDENT
OHIO HEALTH CARE ASSOCIATION

FEBRUARY 25, 1989

Good morning, Senator Metzenbaum, members of the Senate Subcommittee on Aging. My name is Thomas Gault. I am the owner of Harrison House, a 101-bed nursing facility in Cincinnati. I am appearing today as president of the Ohio Health Care Association, an association of more than 400 proprietary and non-profit nursing homes and facilities for the mentally retarded throughout the state.

Thank you for creating this public forum for discussion of the critical issue of care for Ohio's elderly. As Ohio's population continues to age dramatically, this issue will only become more vital to the welfare of our citizens.

The Importance of Quality Care

The most important issue in providing services to our elderly has always been, and continues to be, quality of care. The 90,000 residents of Ohio's nursing homes have the right to receive the highest quality care available. The members of the Ohio Health Care Association are dedicated to preserving the high level of quality which our nursing home residents now enjoy.

Much of our ability to provide high quality care depends on adequate funding. Only adequate funding will allow us to hire the best nurses and other professionals who can provide the loving care which our elderly residents deserve. Only a stable financial position will give our nursing homes the stability to concentrate on providing the highest quality care possible.

There are several factors which cause costs to rise:

- The first is a patient population which continues to grow older and sicker, as the general population grows older and as hospitals discharge their patients earlier to save money. These increasing numbers of older, sicker residents require more intensive care which costs more to provide.

- Another factor is the acute shortage of nurses and other health care personnel. This manpower shortage hampers our ability to provide cost-efficient care because increasing competition for qualified care-givers drives wages up.

- And third, a number of state and federal mandates have recently been imposed which, while improving the quality of care provided in our nursing homes, do cost the state and the nursing homes more to implement. These mandates include increased workers' compensation payments, new conditions of participation, new state licensure requirements, the Catastrophic Health Care Act and the Omnibus Budget Reconciliation Act, about which I will say more in a moment.

These costs are clearly beyond the ability of nursing homes to control. Yet nursing homes have taken the lion's share of the blame for rising costs of care. It is time to move beyond this finger-pointing stage so that we can work together in developing solutions to the funding problems.

The Omnibus Budget Reconciliation Act

I have mentioned the Omnibus Budget Reconciliation Act, or OBRA, as one factor which has meant higher costs for nursing home care. Of course, the costs have been applied toward improvements which ensure high quality care for our residents. Our only concern with OBRA is that it be carried out properly and with adequate funding. We urge the federal government to carefully oversee implementation of the OBRA requirements to ensure that the Health Care Financing Administration and the states carry out the provisions according to your intent.

Protecting the Consumer

The consumer of nursing home services has the right to a quality care setting. While not all nursing homes provide the same level of quality, there are certain indicators that can help nursing home consumers identify the level of quality in a facility. The most important method for evaluation is a personal visit to the nursing home, where the prospective resident and family members can take a careful look at the facility and talk to the various care-givers who work there.

Things to look for in evaluating the nursing home include: current state licenses for the home and the administrator; certification for Medicare and Medicaid; friendliness and helpfulness of the staff to their residents; cleanliness of the interior; convenience of the facility; safety measures such as lighting, handrails and fire precautions; atmosphere in the common areas; state of the bedrooms, dining room and other areas of the home; and availability of services including medical, hospitalization, nursing, pharmacy, therapy, activities, social and food services.

Because OHCA members are dedicated to ensuring our residents receive the best quality care available, we provide a complete checklist of these considerations in our booklet, "The Emotional Decision." In addition, the nursing home resident's Bill of Rights ensures that all nursing home residents can remain informed regarding the nursing home's compliance with state and federal regulations.

State and federal reviews and inspections ensure that all nursing homes in operation meet a certain standard of care. The Ohio Health Care Association has also established a Peer Review program to evaluate the care provided by its member nursing homes. All homes submitting an application for membership in OHCA must undergo and pass a facility evaluation of the services, cleanliness and resident care, from an inspection conducted by a team of nursing home professionals. We also present the "Buckeye Award" to those facilities meeting a standard of excellence in their provision of care, determined by a day-long review of the facility, care and operations.

Another method of evaluating nursing homes which has recently been developed is the Health Care Financing Administration's "Consumer Guide to Nursing Homes." This guide, which gives a sample of state inspection results for nursing homes across the nation, is an important first step in providing information on a broad scale to consumers interested in nursing home care. However, we do urge consumers to view this only as a first step in evaluating a nursing home. The criteria included in the guide represent only a small part of the criteria which are important in determining the level of quality in a nursing home. In addition, the guide does not indicate the degree of seriousness or frequency for any violations, or the home's efforts to correct these problems. Such a guide should never replace the other steps in evaluating a nursing home, particularly the personal visit.

The Growing Need for Nursing Home Beds

The continuing aging of our population signals a growing need for more nursing home beds. As you have probably heard, the statistics regarding the growth of our elderly population are becoming more and more alarming. To give you an example, the number of people 85 years and older in Ohio is expected to increase by 113 percent from 1980 to the year 2010 -- more than doubling in a period of just 30 years. During the same period, the number of people age 85 and older with moderate to severe disabilities will grow by 139 percent. Many of these people will require nursing home care, and we want to be able to provide it.

To help care for the increasing numbers of elderly people, we strongly support development of in-home and community-based programs to supplement nursing home care. Ohio's nursing homes look forward to serving as central locations from which these services can be provided in the community. We have offered to work with the state administration to develop these programs.

Even with the establishment of a wide variety of long-term care options, however, the need for nursing home beds will continue to grow. In-home and community-based care programs will do more than keep people from going into nursing homes sooner than they must. These programs will also bring forth a whole new group of consumers, people who are currently being cared for in their homes by informal care-givers such as family and friends. These people will greatly benefit from such programs as meals on wheels, assisted living, homemaker services, and other programs which can briefly free the informal care-givers from some of the responsibility of providing care. So while we do support in-home and community-based care, and are looking forward to using our experience to help develop these programs, we do urge that attention be paid to maintaining an adequate number of nursing home beds and an adequate level of funding for those who require them.

In conclusion, I want to emphasize what we believe is the superior quality of care provided by Ohio's nursing homes. We have been able to build up this level of quality because of a reimbursement system which reimbursed us for the actual, allowable cost of the services we provide. Now, that system is in serious trouble because of state budget constraints, and indicators for the future show us a population which will grow and need even more care.

Solutions must be reached to help states and nursing homes bear the cost of care for the elderly. I cannot overstate how vital adequate funding is to the future of long-term care in Ohio. Without it, our ability to provide quality care to our residents is in serious jeopardy. We are more than willing to work with the state and federal governments to ensure that Ohio's elderly receive the care they deserve. We thank you for this opportunity to discuss these issues which are so vital to the future of our elderly population, and we look forward to finding solutions for the future. I would be happy to answer any questions you may have.

Senator **Metzenbaum**. We are very pleased Mr. Harris is with us today, and we have been very pleased that he opened his facility to us. I am happy to be here with you and happy to hear from you at this point.

STATEMENT OF LARRY HARRIS, PRESIDENT OF THE OHIO ASSOCIATON OF PHILANTHROPIC HOMES FOR THE AGING AND ADMINISTRATOR OF WILLOW BROOK CHRISTIAN HOME IN COLUMBUS, OH

Mr. **Harris**. Thank you, Senator. As you know, I am the administrator of Willow Brook Christian Home, the facility we are in today. I also served as President of the Association of Ohio Philanthropic Homes and Housing for the Aging. AOPHA is the acronym for that. It is an association of about 240 members, 150 or so which are licensed nursing facilities, all of them are nonprofit.

You are well aware that the over-age 85 population is projected to more than double in the next 30 years, and I think it is clear that a wider range of options is needed to help provide care for those in this age group that need it.

Philanthropic homes in Ohio support the expansion of in-home and community-based choices in long-term care. We believe that these choices will help maintain the independence of people in their own homes and community perhaps longer than otherwise would have been the case.

We feel that nursing homes in Ohio are especially well suited to—as the base for these services. I am talking about such things as meals-on-wheels, visiting nurse programs, homemakers programs, those sorts of things. But these sorts of services and programs will help people, older people remain in their homes for a longer period of time.

The problem it seems to me, though, is that there is little federal funding available for these community-based services. And new federal funding for housing for the elder is very scarce.

The funding that is available does not look—I am talking now in terms of senior housing. The funding that is available for those housing facilities does not recognize a lot of services that might conceivably be provided there to help them remain in their apartment or their cottage and stay out of the nursing home.

I would urge the government to look at some funding, if possible, for some alternate services that would tend to keep people in their own homes.

Senator **Metzenbaum**. Would Elder Care help?

Mr. **Harris**. That's the direct—are you referring to the Governor's initiative?

Senator **Metzenbaum**. Yes.

Mr. **Harris**. With this reservation or with these qualifications, we have endorsed the Governor's Elder Care Program. I think that's a move in the right direction.

But having expressed the support for the expansion of community-based programs, I think it is important to stress that in many cases the in-home services are no substitute for nursing home care and, in fact, we are going to see a greater demand for nursing home beds even with some initiative in the community for the years ahead. And I think that there is a projection for a dramatic increase in the future for nursing home beds even with the community-based services.

Many of the philanthropic homes in Ohio and indeed across the nation are set up as Continuing Care Retirement Communities where we refer to these as CCRC's. These are facilities that offer a wide range of services from independent living all of the way up to skilled nursing care and several levels of care in between on one campus-like setting.

Senator METZENBAUM. Tell us about this CCRC. Continuing Care——

Mr. HARRIS. Retirement Communities. We have our acronyms as well.

Senator METZENBAUM. Yes, I see you do.

Mr. HARRIS. But people living in these retirement communities—once again, it is the full range of levels of care. People living in these retirement communities we feel deserve the convenience and the security of knowing that alternate levels of services are available in this close-knit community. And we suggest that public policy eliminate artificial bed-need formulas for the nursing home for these Continuing Care Retirement Communities.

As it is right now, it is very difficult to build or expand a nursing facility, at least in Ohio, and we are urging that these Continuing Care Retirement Communities have some provision of an exception in their cases.

I think it is obvious there is a correlation, general correlation at least between quality and adequate funding.

Nursing homes must receive payment for the care of the people that we serve. Nursing homes don't have the strong private-pay base to whom we can shift costs for services that aren't reimbursed by Medicare or Medicaid.

[Sneeze.]

Bless you.

Senator METZENBAUM. They say when you sneeze it is true. [Laughter.]

Mr. HARRIS. Historically, Medicaid payments have been inadequate and haven't covered the full cost of care. We are dependent on Medicaid/Medicare to fund care for two-thirds of the people who come to us. Ohio's Philanthropic Homes receive some charitable contributions which offset the deficit incurred on Medicaid/Medicare but certainly those funds are limited as well.

A prospective reimbursement system which would provide for a set reimbursement level for each patient in advance provides dangerous incentives for nursing homes to reduce patient care in order to maximize profits. The elderly in Ohio are fortunate that our reimbursement in this State, when it is allowed to operate properly, contains incentives to provide needed services for residents.

A prospective system such as we have in Ohio now is the best way in my opinion to ensure that the cost for patient care will be met.

Senator **Metzenbaum**. You get paid for what your expenses are, is that what you are saying?

Mr. **Harris**. I'm sorry?

Senator **Metzenbaum**. In Ohio you get paid for what your expenses are, is that what you are saying?

Mr. **Harris**. There is a retroactive adjustment. If your cost had been more than what we anticipated originally, there will be additional funds coming to the home. On the other hand, if the costs were lower than what were anticipated at the start of the funding period, there would be some funds taken from the home.

It more closely reflects the actual cost in the nursing facility rather than simply setting a reimbursement rate, say, at the beginning of the year, and then regardless of what the costs were through the year, that's the funds that the home would receive.

Senator **Metzenbaum**. Are their different rules for nonprofit as compared to profits?

Mr. **Harris**. No, it is essentially the same. There are a few major differences between the reimbursement system but it is essentially the same.

Senator **Metzenbaum**. What is the incentive, then, to operate on an economical basis, not the one Blue Cross/Blue Shield used, to have—to have the formula of retroactive reimbursement of expenses and pretty much had to throw that out of the window as did the Federal Government.

I was under the impression that nursing homes operated under whatever the Medicaid or Medicare allowances were and then used that money to know what they were going to get.

You are saying that each nursing home takes application for a retroactive adjustment; is that right?

Mr. **Harris**. Yes, that's inherent in the reimbursement system. There are some cost-efficient incentives within the system. There are, for example, in the area of the administrative and general costs, if a nursing facility can maintain its cost below a state-wide average, there is a portion of the cost savings that is shared with the facility and that in essense become a surplus in profits and that's an incentive to keep those costs down.

Senator **Metzenbaum**. I do have some additional questions which I may submit in writing, but Mr. Chester Stroyny, the Regional Administrator of HCFA, has come here from Chicago. He has a plane to catch. And I think he has been very patient to sit through this entire hearing. Frankly, with due respect to his family obligations, I think I will bring this segment of the hearing to a conclusion and—ask Mr. Stroyny and Dr. Ronald Fletcher to come to the panel. Thank you very much. Hope you will follow up.

Mr. **Gault**. We will.

Mr. **Harris**. Thank you, Senator.

Senator **Metzenbaum**. How many philanthropic homes are there?

Mr. **Harris**. We have at membership in our association of nursing facilities about 150?

Clark, help me out.

Unidentified Person. You are about right.

Senator **Metzenbaum**. All nonprofit?

Mr. **Harris**. Yes. And we have probably 85 percent of the nonprofit facilities in our association that are in Ohio.

I am guessing; is that about right?

Senator **Metzenbaum**. Thank you.

[Mr. Harris' prepared statement follows:]

PREPARED STATEMENT OF LARRY HARRIS

DRAFT

My name is Larry Harris. I am the administrator of Willow~~b~~Brook Christian Home, a 50-bed non-profit nursing facility in Worthington. I am here today as president of the Association of Ohio Philanthropic Homes and Housing for the Aging, or AOPHA, a group which has been in existence for 51 years. Its members are a diverse group of non-profit facilities united in a common goal of providing the highest quality care possible for Ohio's elderly.

You have been informed many times of the alarming rate at which our population is aging. The over age 85 population group is projected to more than double from 1980 to the year 2010. Currently, 23 percent of the people in this age group reside in nursing homes. Clearly, a wider range of options is needed to ensure that all those who need care receive it.

Ohio's philanthropic homes support the expansion of in-home and community-based choices in long-term care. We believe that these choices will help people maintain their independence as long as possible. Ohio's nursing homes are particularly well-suited to help in establish~~ment of~~ing these programs, particularly since many AOPHA members, for years have been ~~for years~~

by providing home health services, meals on wheels, adult day care programs and other services which help adults remain in the community as long as possible.

The problem has been, and continues to be, that little federal funding is available for adult day care, respite care, home health care and other community-based services. New federal funding of housing for the elderly is almost non-existent, and certainly is not keeping pace with the growth in the elderly population. The funding that is available does not recognize other services which must be provided in an effective senior housing program -- counseling and social services, homemaker and meal programs. A lack of funding for these important services forces people out of senior housing and into nursing homes more quickly than necessary.

Having expressed our support for the expansion of community-based
, in many cases, in-home services
programs, it is important to stress that these expanded programs will not
are no substitute for NH
mean a drop in the number of nursing home beds needed. On the contrary, the projections for dramatic increases in our elderly population indicate that the need for both nursing home and community-based programs will continue to grow.

Many of Ohio's philanthropic homes are arranged into Continuing Care Retirement Communities, or CCRC's. These communities, which combine nursing home, senior housing and community-based programs all on one campus-like setting, particularly should to be allowed to expand their nursing home programs as the needs of their residents increase. Elders deserve the convenience and security of knowing that alternate levels of service are all available in the same close-knit community. Seniors are reluctant to enter into housing and other programs unless they feel secure that nursing home care will be provided when they need it. We suggest that public policy eliminate artificial bed-need formulas contained in various state certificate-of-need programs throughout the country for these CCRC facilities.

Quality Care Depends on Adequate Funding

There is a simple correlation between quality and adequate funding. Nursing homes _must_ receive payment for the care of the people we serve. Because the state and federal governments establish the criteria for admission to nursing homes, it is the responsibility of these governments to ensure that funding will be provided for the patients we serve.

Nursing homes do not have a strong private-pay patient base to whom they can shift costs which are not reimbursed by either the Medicare or Medicaid program. Moreover Medicaid rates have been inadequate & have not cover cost of care. We are dependent on these programs to fund the care for 2/3 of those patients who come to us. Even for philanthropic homes, receive some charitable contributions to help offset the [illegible]. But charitable contributions are limited, while the unreimbursed Medicare and Medicaid costs continue to grow.

A prospective reimbursement system, which would provide for a set reimbursement level for each patient in advance, provides dangerous incentives for nursing homes to reduce patient care in order to maximize profits. The elderly in Ohio are fortunate that our reimbursement system, when allowed to operate properly, contains incentives to provide needed services to our residents. The system also allows administrators of the system to determine exactly where the money is being spent for nursing home services to our Medicaid patients. (Please see Attachment A to this testimony for an average per diem breakdown of expenditures by the type of service provided.) A retrospective reimbursement system like ours, allowed to operate properly, is the best way to ensure that costs for patient care will being met.

Unfortunately, the knowledge that full Medicaid funding is essential has not prevented funding cuts. In recent years, Ohio has reduced payment rates as a result of the flexibility contained in federal statute (i.e., the Boren Amendment), and this has seriously harmed our ability to provide much-needed services.

Ohio's elderly should no longer be punished when the Medicaid budget grows beyond expectations. Ohio's philanthropic homes strongly urge that funding for the services we provide to the elderly be based on human needs rather than budgetary constraints.

Ohio's nursing homes are experiencing some frustrations regarding state and federal regulation of nursing homes. I appreciate the opportunity to give you the perspective of Ohio's philanthropic homes regarding some of these problems.

Omnibus Budget Reconciliation Act

One of our biggest concerns deals with the requirements of the Omnibus Budget Reconciliation Act (OBRA). We are certainly supportive of increasing training of nurses aides, and believe that initiatives designed to improve the quality of patient care are always welcome.

However, the OBRA requirements cause harm to Ohio's small Intermediate Care Facilities (ICFs). In Ohio, there are 129 facilities with 25 beds or less. There are 288 with between 26 and 50 beds. These 417 small facilities offer a family atmosphere in which the residents and staff develop a bond which cannot be duplicated in a larger home.

After October, 1990, these homes will be required to meet Medicare skilled nursing staffing standards. They will need to increase staffing for nursing dietary, social services, and utilization review functions. These initiatives simply cannot be effectively accomplished in facilities of this size. Small homes have too small a base over which to spread the costs of these added services and remain cost-efficient. Only facilities of 100 beds or more -- homes built on the more institutional, medical model -- will be able to operate efficiently under these requirements. even then [illegible] Nursing homes will undergo a revolution, becoming much like sub-acute care units, or one step down from acute hospital care. Unfortunately, an important, caring option in long-term care services will be lost for many of the state's elderly.

Although the state and federal governments have at times maintained that as many as 20 to 30 percent of people in intermediate care facilities do not need to be there, we strongly protest that this is not the case in Ohio. The vast majority of nursing home residents who currently reside in ICF facilities suffer from such debilitating conditions as dementia, disorientation, Alzheimer's disease and paralysis. While these people do not yet need 24-hour skilled nursing care, they simply cannot live on their own or in a less supportive environment. They need constant supervision and assistance with daily tasks. The small ICF homes have been able to provide these services in an atmosphere that is warm and loving. We urge some protection for the small ICF facilities which are being phased out by the OBRA requirements.

In addition, we urge that the federal government be watchful of those entrusted with implementation of these nursing home reform initiatives. OBRA contains an unusual provision that states must implement the requirements regardless of whether HCFA has fulfilled its responsibilities to provide guidance. States, nursing homes and recipients of care now have to comply with a law whose requirements have not been clearly defined. In the OBRA requirement for preadmission screening of nursing home residents for mental illness and mental retardation, homes were required to begin the screening process January 1, 1989. However, the critical definition of "mental illness" has changed several times. If facilities admit residents who have not been properly screened because of inconsistent criteria, they run the risk of having payment denied and jeopardizing their Medicare and Medicaid certification.

I have stated that we support initiatives which will help us raise the quality of nursing home care for our patients. Ohio's philanthropic homes have long dedicated themselves to improving patient care in every way possible. Yet at some point, it is necessary to assess whether the improvements in patient care are truly worth the cost in both dollars and problems for patients.

HCFA Consumer Guide to Nursing Homes

Another frustration shared by nursing homes regarding federal regulation of nursing homes is the publication of the Health Care Financing Administration's "Consumer Guide to Nursing Homes." We do not object to the idea of a guide which will help consumers choose nursing facilities which deliver high quality care appropriate to their needs. We only object to the make-up of the guide, which presents a distorted picture of the quality in the nursing homes. The guide does not distinguish between severe and minor infractions and does not indicate the frequency of the problems.

Let me give you an example of how the guide distorts the actual situation within a nursing home. In my facility, Willowbrook Christian Home, the guide reported that three of the thirty-two performance indicators were not met. A closer look back at the survey revealed that the problems in these three categories were not serious, they were not observed frequently, and we had taken immediate steps to correct them. For example, we received a "not met" rating in the standard, "Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions." The violation of this standard, which sounds like it could indicate serious hazards to our residents, actually resulted from one meal at which meat was served at 104 degrees rather than the required 120 degrees. The consumer has no way of knowing the seriousness of the problem.

The guide does not always distort the situation toward the negative. The Ohio Department of Health filed suit against one Columbus home in September to force its closure because of "imminent life-threatening situations." Yet in December, the HCFA Consumer Guide was released, giving this same facility a perfect score. Clearly, the guide cannot be recommended as a reliable resource for assessing the quality of care in a nursing home.

Eligibility for Medicaid

The final concern I would like to mention today is the issue of eligibility for the Medicaid program. The Medicaid program is being treated as "inheritance insurance" by many people in nursing homes today. Some elderly voluntarily admitted to a NH are systematically divesting themselves of their assets in order to qualify for Medicaid. Attorneys and county human services workers regularly advise their clients on the mechanics of this process. The families of nursing home residents are denying their responsibility to help pay for the care of their parents. Clearly, this country has reached a crossroads in the delivery of long-term care services. We cannot continue to punish those nursing home residents who display honesty or ignorance by openly reporting their assets, and reward those with the knowledge to cheat the system. We now must make a decision: do we want to provide long-term care services as a basic entitlement program for everyone who needs it, or do we want to more carefully enforce eligibility requirements and reserve the already growing Medicaid program for the truly needy? We urge the federal and state governments to develop and implement policy on this issue.

Ohio's philanthropic homes are deeply dedicated to providing the highest level of care possible for our residents. Whether they require 24-hour skilled care or a level of independence offered by community-based services, AOPHA members strive to help their patients live as fully as possible. Unfortunately, this kind of dedication cannot continue indefinitely without adequate funding. We urge the support of the federal and state governments in helping us provide care to those people whose world has been reduced to half a room.

Senator Metzenbaum, I would be glad to answer any questions you may have at this time.

Senator METZENBAUM. Mr. Stroyny, we are very, very happy to have you with us. And why don't you proceed. And then if you have to leave in order to catch a plane while Dr. Fletcher is speaking, he will understand.

Mr. STROYNY. I will catch a later plane. This is important, what I have been hearing this morning is very important. And so if it runs a little longer and you have time, I will stay longer than that.

Senator METZENBAUM. Thank you.

STATEMENT OF CHESTER C. STROYNY, REGIONAL ADMINISTRATOR FOR THE HEALTH CARE FINANCING ADMINISTRATION, CHICAGO, IL

Mr. STROYNY. My name is Chester C. Stroyny and I am the Regional Administrator for the Health Care Financing Administration in Chicago.

I am going to say good afternoon to you, Senator Metzenbaum, and to say that I am pleased to be here. For those of you who don't know, Region V is a six-state region composed of Ohio, Illinois, Indiana, Michigan, Wisconsin and Minnesota.

I am a representative of the Health Care Financing Administration and the Regional Administrator and chief spokesperson in this region for our agency. We are a part—as you know, a part of the Department of Health and Human Services.

Very recently Dr. Bowen, former Governor of Indiana, was our secretary and now Dr. Lewis Sullivan is in the process of being confirmed as the new Secretary of our Department.

I will beg your indulgence, Senator, and read my testimony, if I may. If you want to stop me or whatever, just go ahead since this represents the position of my agency, it is not my personal opinion.

Senator METZENBAUM. I understand you are speaking both for yourself and HCFA nationally.

Mr. STROYNY. Yes, sir. I listened carefully to the serious concerns presented by the resident advocates and providers this morning and this afternoon.

I assure you we in HCFA have a common goal of assuring quality of care in our nation's nursing homes.

I am here today to discuss the quality of care and quality of life in nursing homes. The overall quality of care in America's nursing homes is good, we feel is good; however, HCFA readily acknowledges that improvements are desired and necessary.

In a 1986 reort, that was already referenced to this morning, the Institute of Medicine found that the Federal Government's regulatory and enforcement efforts over the past decade have been a major factor in promoting improvements in our nation's nursing homes.

As we move forward to implement the changes included in the Omnibus Budget Reconciliation Act of 1987, which was passed by the Congress in December and enacted into law on December 22 of 1987, this was based on the recommendations of the IOM Report, a great deal of this legislation comes right from that report as you well know as well as the proposed rules published by the Health Care Financing Administration in October of 1987, the quality of care and life will continue to improve for the residents in America's nursing homes.

On February 2, HCFA published final regulations [with a comment period] that revised and consolidated the requirements that facilities furnishing long-term care must meet to participate in both the Medicare and Medicaid programs.

These regulations, composed of approximately 53 pages, contain revisions to our proposed rule which we had published October 16 of 1987, before OBRA was passed, and some changes created by the enactment of OBRA.

These "Requirements for Long-Term Care Facilities" focus on facility performance and patient outcome rather than on procedural or paperwork requirements.

The object is to require that a facility provide each resident with the necessary nursing, medical and psychological services to maintain or enhance the quality of care for each resident.

Some of the major features of the final regulation include: Enhance residents' rights, strengthen quality of care and requirements designed to enhance residents' quality of life.

Also included are resident assessment requirements and additional health care services, such as, routine and emergency dental care and a full-time social worker for facilities with more than 120 beds.

To completely satisfy OBRA '87, the 1987 requirements, as was pointed out correctly by you this morning, additional regulations will be issued at future dates.

One of these will implement survey and certification and enforcement processes. It will specify the tools to be used in enforcing the facility requirements. Other detailed aspects of OBRA 1987 will be contained in another regulation.

As you know, OBRA 1987 included a "Bill of Rights" for residents, which is included in our regulation. This addresses, among other things, the residents' right to free choice of a personal attending physician and right to be fully informed in advance about care and treatment.

It also includes freedom from restraints, including being freed from physical or mental abuse or punishment, and the right to privacy.

The law also requires that a nursing facility inform each residence, both orally and in writing at admission, of the resident's legal rights during the stay, the rights of residents judged incompetent under state law and transfer and discharge rights.

I want to emphasize that all requirements for certification must be met by nursing facilities. In the past, we used the condition of participation which is a statutory requirement. This format led to some misunderstanding that violations of "lesser" requirements would not be subject to federal enforcement.

I want to assure you we will no longer use the traditional "conditions" and "standards" terminology in our regulations. We want nursing facilities to recognize that all of the nursing facility requirements are binding and that all are important.

At this—at the same time, we recognize that violations of these requirements, depending on their type or severity, may be remedied through the different enforcement mechanisms available to the Department, as the Ombudsman from the State pointed out this morning.

The Department's enforcement regulations will describe the options available under the statutes to remedy the different kinds of violations of federal certification requirements.

Another significant step in our efforts to provide information to the consumer is our publication on nursing homes that was referenced this morning.

Last December, HCFA issued, for the first time, detailed information on the population and performance of each of the 15,000 nursing homes that participate in the Medicare and Medicaid programs.

The publication entitled, "Medicare/Medicaid Nursing Home Information," consists nationally of 75 volumes, with at least one volume for each State in the District of Columbia.

I am sure, as you are well aware, individuals in this room are aware in the State of Ohio, and they have—I am sure some of you have reviewed the volume for this state and are familiar with the information.

The publication contains a profile of each nursing home derived from the latest on-site survey conducted by the State Health Department, in this case, Dr. Fletcher's group. It reflects conditions in the nursing home at the time of its most recent survey and includes a summary of the characteristics of the residents in each home, their functional capacities and care needs.

The profiles also indicate whether a facility was deficient at its last inspection in any of 32 selected performance indicators useful in describing a home's performance, such as, cleanliness, rehabilitative services, proper nursing capabilities and food quality.

There is also an overview of each state's licensing and enforcement program, with the telephone numbers for key local, state and federal agencies and advocacy groups.

HCFA felt that in making the information public we have stressed that the—in making the information public, we have stressed that proper and responsible use of the information depends on an understanding of the enforced limitations which we readily admit.

For example, the deficiency rates are a "snapshot" of conditions in the home at the time the survey was taken. They do not describe the severity or the duration of the problem or the nursing home's promptness in correcting the deficiency.

The reverse is also true: An indication of a home's compliance at the time of the survey is no guarantee that the home still measures up to the standards for that particular performance indicator today.

HCFA worked closely with many representatives of the nursing home industry, consumer groups, state governments, and Congressional offices in deciding what information to present. Reports were widely distributed to Congressional offices, state survey agencies, professional associations, Ombudsman's offices and Medicaid agencies.

We intend to have annual releases of this publication, and I am sure it will be improved in the future and believe that the consumer will find it one of several useful tools when the need arises to select a nursing home.

And I want to stress that when this information was made public it was emphasized that this was just one tool that an individual family or relatives could consider when considering a nursing home placement for a loved one.

We are committed to careful and orderly changes in our regulation of nursing homes. We recognize that both defining and assuring quality can be accomplished only through the cooperative spirit among Congress, the administration, the States, the provider community and consumers. I can assure you on behalf of the Administration of its commitment to reach our shared objectives.

Thank you, Senator, for inviting HCFA to testify at this hearing.

Senator METZENBAUM. Thank you very much, Mr. Stroyny.

One has difficulty in commenting on a 75-volume presentation which has already been subjected to a lot of criticism coming from all sides; the Advoçates of Nursing Home Reform, as well as nursing home operators.

As I understand it, the directory was not part of OBRA, it was a separate initiative, not a release of unavailable information.

There are some, frankly, that feel that the resources and time spent on the guide would better have been utilized to meet OBRA deadlines. I wonder if you will comment on that.

Mr. STROYNY. Okay. I will. I guess I anticipated that question.

Based upon my knowledge of the individuals working on the proposed or the regulations that came out February 2, which was a very comprehensive regulation to address the OBRA statutory requirements, and there are other regulations to follow in the spring, related to enforcement and other aspects of OBRA, those individuals, the majority of those are in what we call your policy component that takes the statutory law and translates it into regulations.

The other component in our headquarters in Baltimore, Maryland who worked on the nursing home data release, those individuals drew the data for the nursing home data release from our computer banks.

You are correct, there are some of those same individuals who have been involved in the OBRA regulation development and working with our policy staff.

I am not going to argue or contradict your—the point you have made. I think you have made a valid point.

Our Department's position is that we haven't missed that many deadlines in light of the overall number of deadlines in OBRA. Many of the provisions are not effective until October 1 of 1990, January 1 of 1990.

Senator METZENBAUM. [Indicating.]

Mr. STROYNY. Yes, you are correct on those. But there are many there coming up October 1, 1990, such as 24-hour nursing service, changing the definition of a nursing facility, enforcement, there are many other enforcements effective October 1 of this year. And we are working very diligently to get the enforcement reg out, that I have been told that we will have it in the spring.

Senator METZENBAUM. I can't hold you responsible for the entire agency, but the fact is, October 1990 is a ways away, some period away. These are deadlines that Congress set forth. And this concern, the 75 volume work, which just sort of blows my mind, to have 75 volumes, I can't even contemplate what the expense was in putting that together.

Do you happen to know what the expense is?

Mr. **Stroyny**. I do not know but I could get that for you. It is available.

Senator **Metzenbaum**. I think it would be fantastically expensive and I don't know that it was serving a special purpose. But the fact is, while you were doing that, you didn't meet these deadlines.

Now, you have got a new boss coming on board. I think he will be confirmed this week. I am pretty sure he will be confirmed this week. And I just think that it's important in your presence here for you to take back the message that we are unhappy—and I am sure I speak for all of the members of the Senate—with the failure of HCFA to meet the obligations imposed upon it by law and a feeling that some of the time spent on the 75 volume work would have been better used complying with OBRA.

Mr. **Stroyny**. I will certainly do that, Senator.

Senator **Metzenbaum**. And I think that you should know that we in the Congress, we who serve on that committee, we are not looking for a scapegoat, we are not looking to fine somebody, we are not looking for political objectives. We are looking for results and solutions.

And we are prepared to work with you, help you, and I think if no one message comes out of this hearing, your being here is that, yes, we are unhappy with what you did yesterday, but we hope that tomorrow would provide much better working relationships, much better implementation of OBRA, and, frankly, bottom line, much better care and treatment for the senior citizens who are residents of these facilities about which we have been speaking today. Certainly there are many problems out there.

Mr. **Stroyny**. What my Department and our agency expects, sir, is to implement the Nursing Home Reform provision of OBRA as quickly and effectively as possible and I will certainly take that back with me. Thank you.

Senator **Metzenbaum**. I am grateful to you. You are welcome to stay.

Mr. **Stroyny**. I will be happy to hear the rest of the testimony.

Senator **Metzenbaum**. Dr. Fletcher.

STATEMENT OF DR. RONALD FLETCHER, ADMINISTRATOR, OHIO DEPARTMENT OF HEALTH, COLUMBUS, OH

Dr. **Fletcher**. I will abbreviate my testimony for time sake but try to focus in on the critical issues.

Senator **Metzenbaum**. Thank you.

Dr. **Fletcher**. The quality of care provided to nursing residents is of critical concern. I believe the changes in quality assurance programs which have occurred over the last several years have been positive.

For example, the Department of Health supports the increased emphasis which the Medicaid and Medicare certificate survey standards place on patient outcome.

In addition, during the last five years, the Health Department has increased its nursing home survey staff from 80 to 1,200 persons. We have been able to be more timely in our surveys, more effective in our enforcement action and have benefited greatly from the increased staff expertise through the use of license dieticians, licensed code experts and qualified mental retardation professionals.

I believe the State of Ohio Model Nursing Home Resident Bill of Rights and work of the states' Ombudsman office has already—have already enhanced the quality of life for nursing home residents in these states.

The State of Ohio and Department of Health support many of the OBRA reforms enthusiastically, through the provision on the residents' rights of revision to plan of care on the patient assessment requirements, in recognition that residents may have psychological as well as medical and nursing needs. The new law acknowledges that a good quality of life should be the true goal of nursing home residents.

OBRA also deals with the need for training qualified staff, requiring the addition of registered nurses and training for nurses aides. I feel that this is most important.

The Department of Health has already requested and received statutory authority to fully implement the Medicaid and Medicare nursing aide training requirements of OBRA. In fact, we have incorporated the training requirements as part of our nursing home licensure law to ensure an equitable and consistent quality of staff across all nursing homes in the state.

Our efforts to implement the nurses aides training requirement, however, have been hampered in two ways: First, the time frames of implementation by the states are unrealistic.

Through dedication of significant staff time and the service of outside consultants, we hope to begin the process of approving training programs within the next two months. However, we will be at least four months behind schedule outlined in OBRA. This delay may jeopardize the ability of nursing homes to comply with the deadlines and law.

We plan to have a nurses aide competency evaluation program available by July of this year as required by the law. But we believe the logistics of offering a written and skills demonstration of evaluation to over 35,000 aides used in Ohio's nursing homes will make it impossible to meet the January 1, 1990 deadline of completion.

This is especially true since aides must be given up to three chances to pass a competency evaluation. This would calculate to be 800 tests per working day.

Senator METZENBAUM. Dr. Fletcher, you are giving me a lot of stuff. Please zero right in on the problem of what the Department of Health is doing vis-a-vis the nursing homes of this State, supervision of them, the suspension of them, what is bringing them up to standard so that they don't have some of the problems we are talking about today.

All of your statements will be in the record. You are getting me into the technical stuff. I want to deal with the patients.

Dr. **Fletcher**. Focusing in on that, sir, at this point we are working, with regard to OBRA, trying to get to the point in which we have intermediate sanctions, and that's one of the principal points of my text, intermediate sanctions.

At this point, the State of Ohio has very little it can do, it is an all-or-none response. We see problems in nursing homes, and virtually the only thing we can do is close those nursing homes down.

We have already heard about the serious difficulties that have been described and suffered by individuals with regard to transfer, but when one closes a nursing home down, there is nothing else left for one to do save transfer.

Senator **Metzenbaum**. What do you do if you get a complaint?

Dr. **Fletcher**. If we have a complaint? There are a series of levels of complaints. If it is a complaint that deals with concerns of life and safety, we have our surveyors and investigators in that home within 24 hours to evaluate that.

Senator **Metzenbaum**. If it is just a complaint that they are doing a lousy job, it is dirty, it is filthy, that the patients are tied down to chairs, that the patients are kept in their beds without clean sheets, et cetera, what do you do?

Dr. **Fletcher**. As part of our survey process, we go into that home and those are specifically mentioned against that particular home.

Senator **Metzenbaum**. What do you mean "as part of our survey process"?

Dr. **Fletcher**. Part of the survey process is to look at all aspects of care. That includes such things as diet, how the patients are treated, outcome, all of those phases.

Senator **Metzenbaum**. Are the homes notified before you go in?

Dr. **Fletcher**. No, sir.

Senator **Metzenbaum**. Let me ask you: A patient calls in or a person calls and says, "My father is in a home. It is just so horrible" and gives you some specifics about how horrible it is.

How long would it be to—turn-around time before somebody from the State would go to that home?

Dr. **Fletcher**. Again, sir, that would depend on the level of the complaint. If it was a complaint that dealt with issues of life and safety——

Senator **Metzenbaum**. No, it is not life and safety. But I will tell you something: You can die while being alive. I don't have to make that point to you. You can die while being alive.

You are an old person. You are left to sit in your own urine, your own feces. You have horrible food, the place is dirty, you don't get clean bed clothes, you get abused by the attendants. That may not be a matter of life and death.

But what bothers me is why can't the State of Ohio—you say you don't have authority to do anything but pull the license. I will tell you something: When a state official walks into one of these homes and starts to raise cain and says, "Get this straight and get that," nobody is really going to say, "Oh, you can't do anything to me. All you can do is pull my license," they will shape up because they want to get you off of their back.

My question is: If—you answered now twice, Dr. Fletcher, if it is a matter of life and death, is that what you said?

Dr. FLETCHER. Life and safety.

Senator METZENBAUM. You go in. Why not more? Why not more?

Dr. FLETCHER. There are a number of other concerns, complaint levels. We may respond, depending on that level, within a week. There are some types of concerns that may be responded to within 30 days or it might be part of the regular survey process.

Senator METZENBAUM. How many people do you have in your department?

Dr. FLETCHER. With regard to the survey process we have 800.

Senator METZENBAUM. What does "survey" mean?

Dr. FLETCHER. Those are the nurses, the ones that are trained and certified to go into these homes and to make evaluations of complaints.

Senator METZENBAUM. What do you do with 800 of them? What do they do?

Dr. FLETCHER. At this point there are at least 1,000 nursing homes in the State of Ohio.

Senator METZENBAUM. Okay. How often do they get into each one?

Dr. FLETCHER. The standard survey procedure is once a year, and that procedure——

Senator METZENBAUM. Mathematics have blown my mind. You have got 800 people to do the job. You have got 1,000 homes. They get in once a year. What do they do the other 364 days a year? I am lost.

Dr. FLETCHER. The process of surveying is an extremely long and tedious process which requires anywhere from two to—again, depending on the particular incident in the nursing home, could be several weeks.

What happens is the surveyor goes in. If they find a concern, they will continue to go back to that nursing home focusing in on that concern to make sure it is under change which would render an improvement or elimination of that difficulty.

If, however, after a certain period of time, that nursing home does not comply or does not submit a plan of correction, then we are obliged to move towards closing that nursing home.

Senator METZENBAUM. Your responses are—this whole question of survey, who cares about a survey? Send them in and raise some cain. Send them in and do something about it. 800 people; 800 people for 1,000 homes. That means you could have one for every single day of the week almost for each home, practically speaking. You only have to have one-fourth of them get two homes. I don't understand what they do with 800 people.

Dr. FLETCHER. We do send them in to raise cain. The problem is raising cain and getting folks to respond also deals with a system of the legal system. And unfortunately, it is very difficult when going to go to a local judge to say, "Something is afoot in this this place. They will not do anything about it. We want it closed."

Senator METZENBAUM. Doctor, how long have you been the head of the Department?

Dr. FLETCHER. Approximately two years.

Senator METZENBAUM. Couldn't you have gone to the legislature saying, "I need more authority. I don't want to have to close these places. I want to be able to go in, do this, do that, same kind of things that OBRA proposes." Couldn't you have gone to the legislature and asked for that?

Dr. **Fletcher**. As of the time I was coming into that position, OBRA was in place, or at least OBRA was being implemented so we knew that intermediate sanctions were coming. And that is why we moved to incorporate intermediate sanctions into our State law.

Senator **Metzenbaum**. Doctor, if your people walk in and say, "Look, you have got roaches here, you have got vermin here, you have got urine on the floor, you have got clothes over here sitting on the floor that's dirty and filthy," you mean to say you walk into that facility and you ask for the director or the owner and you say, "Look, shape up, get this out of here, get this cleaned up within 24 hours and I will be back," do you mean to say they won't do it because all your authority is to withdraw their license?

Dr. **Fletcher**. Senator Metzenbaum, I have walked into nursing home and have made those statements. And in many instances there are corrections that are made, but I cannot say that that happens in all instances. And that is why we have moved on a number of occasions to have those homes closed.

Senator **Metzenbaum**. Doctor, the next time you get some of these homes that won't do what you think has to be done, pick up the phone. I will get them closed, I will—I will get them cleaned up, if you will let me know how. I will get them cleaned up one way or the other.

And one thing, obviously, that is always there is the force of public opinion, the embarrassment of having a home that's being sanctioned publicly. But I would say to you, if you know the home that lady was talking about down in Cincinnati——

Dr. **Fletcher**. Personally I am not aware of that home.

Senator **Metzenbaum**. Well, I have asked that Mr. Gault check into it. I am asking you to check into it. If there are any homes that are not up to standard, you let Dr. Fletcher know, let him know what the problem is, write him personally, call him, you'll get an answer from him, or call me, call me, because I am upset.

I am not one who can live with bureaucracy and the fact that this is taking so long. At this very moment there are people in homes in Ohio who aren't getting the care they are entitled to.

I am not saying they are all supposed to have beautiful facilities. This happens to be a lovely facility we are in. I am not saying everyone has to be as well kept as this one, but some of them don't have to be as poorly kept as they presently are.

Doctor, I am prepared to work with you. I am not a supervisor, as such, but I have a loud voice. And I am willing to help you by using that voice if you can't get some nursing homes straightened out as they should be.

And I would say to you both, we want—we want senior citizens who are unprotected in these nursing homes given the kind of protection that both the state and Federal Government owe them, and let's try to work at that.

Dr. **Fletcher**. Senator, we will welcome your help. And again, with the proposed OBRA legislation, we will be able to do such things as to level civil fines against these institutions. We will be able to send in teams to take over those institutions and make sure they are run properly by the appropriate individuals. We will be able to do much more.

Senator **Metzenbaum**. Let's do it before OBRA gets fully in place. Let's do it today, not wait for all of that implementation. Let's do it with what resources we have. And it can be done. I am convinced it can be done. I am willing to try to help you personally, if necessary.

If I run into too much difficulty, I will get Richard Celeste, who I know is very efficient, a good friend. Richard will help me do what needs to be done in order to smoke out these problems.

So with your help, my help and Richard's help, we will solve the problem. And I know we will get the kind of support in this new administration that will make for headway on this subject.

[The prepared statement of Dr. Fletcher and additional material supplied for the record follows:]

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RICHARD F. CELESTE
Governor

TESTIMONY
To
UNITED STATES SENATOR HOWARD M. METZENBAUM
UNITED STATES SENATE SUBCOMMITTEE ON AGING
By
RONALD L. FLETCHER, M.D.
DIRECTOR OF HEALTH
February 25, 1989

As Director of the Ohio Department of Health, I am pleased to appear before this special hearing today to discuss the critical issue of long term care quality in Ohio. In Ohio, the Department of Health is responsible for licensure of nursing homes, for the survey of Medicare-certified nursing homes and for the survey and certification of Medicaid-certified facilities.

One of the greatest challenges facing Ohio and the nation is meeting the long-term care needs of our rapidly aging population. In addition to the elderly, there are other populations of frail adults and young people who need long-term care services, whether due to mental illness, mental retardation, developmental disabilities or medical conditions which require complicated or "high-tech" care over a long period of time.

The major source of long-term care services in Ohio has been and continues to be nursing homes, and the major payors for these services are the state and federal government, primarily through Medicaid and to a much smaller extent, Medicare. The largest single item in the State of Ohio's budget is the Medicaid line, and 40 percent of Medicaid dollars in Ohio are spent on long-term care services -- almost all of it in nursing homes.

The quality of care provided to nursing home residents is of critical concern. I believe that the changes in quality assurance oversight which have occured over the last several years have been positive.

For example, the Department of Health supports the increased emphasis which the Medicaid and Medicare survey standards have placed on patient outcome. In addition, during the last five years, the Health Department has increased its nursing home survey staff from 80 to 200. We have been able to be more timely in our surveys, more effective in our enforcement action, and have benefited greatly from increased staff expertise through use of licensed dieticians, sanitarians, life safety code experts and qualified mental retardation professionals. I believe that the State of Ohio's model Nursing Home Resident Bill of Rights and the work of the state's Ombudsman's office also have enhanced the quality of life for nursing home residents in this state.

But problems remain. These problems were detailed in the Institutes of Medicine report of 1986, "Improving the Quality of Care in Nursing Homes", and were echoed in hearings before Congress. The Congressional responses to the issues raised were incorporated in the Omnibus Budget Reconciliation Act of 1987. The National Senior Citizens Law Center has called these provisions the "most comprehensive nursing home reform legislation since the creation of the Medicare and Medicaid programs." I believe that this is an accurate account of the importance of these provisions.

The State of Ohio and the Department of Health support many of the OBRA reforms enthusiastically. Through its provisions on residents' rights, revisions to the plan of care and patient assessment requirements, and recognition that residents may have psychosocial as well as medical and nursing needs, the new law acknowledges that a good quality of life should be our true goal for nursing home residents.

OBRA also deals with the need for trained and qualified staff, requiring the addition of Registered Nurses and training for nurse aides. The Department of Health has already requested and received statutory authority to fully implement the Medicaid and Medicare nurse aide training requirements of OBRA. In fact, we have incorporated the training requirements as part of our nursing home licensure law, to assure an equitable and consistent quality of staff across all nursing homes in the state.

Our efforts to implement the nurse aide training requirements have been hampered in two ways. First, the time frames for implementation by the states are unrealistic. Through dedication of significant staff time and the services of outside consultants, we hope to begin the process of approving training programs within the next two months; however, we will still be at least four months behind the schedule outlined in OBRA. This delay may jeopardize the ability of nursing homes to comply with the training deadlines in the law. We plan to have a nurse aide competency evaluation program available by July of this year, as required by the law, but we believe the logistics of offering a written and skills demonstration evaluation to the over 35,000 aides used in Ohio's nursing homes will make it impossible to meet the January 1, 1990 deadline for completion. This is especially true since aides must be given up to three chances to pass the competency evaluation. This would calculate to 800 tests per working day.

The second problem we've encountered in implementation of the training provisions is that the timeframes have apparently also been impossible for the federal agency to meet. HCFA has not yet issued the final nurse aide training guidelines which were due in October of 1988. The State of Ohio is now between the proverbial rock and a hard place. If we delay implementation until the regulations are available, we face possible audit exceptions, and the state's nursing homes face decertification penalties beginning next year. If we implement the training program using our best guess about program standards as Congress requires in OBRA, we risk the confusion and cost of having to modify our program at a later date when the regulations finally are issued.

I urge Congress to do anything in its power to help resolve this impass. For OBRA to be implemented effectively, federal guidelines must be made available in a more timely manner.

An additional, potential problem is the cost of implementing the training and evaluation requirements. Our preliminary estimates are that it may cost as much as $7 million just to compentency evaluate those nurse aides currently employed by nursing homes in Ohio. While we are pleased that the federal government is providing enhanced federal matching funds for the first year of training implementation, unless we can find a way to stem the tremendous turnover in staff currently experienced by nursing homes, the on-going costs of meeting the training and testing requirements will be significant.

State and federal policymakers, as well as nursing home administrators, should consider carefully whether it would be better to invest in increased wages or other benefits for nurse aides to encourage longevity, rather than to continue to spend millions of dollars to train minimum wage workers who will take their training with them when they move on to work at McDonald's.

With regard to the survey and certification process, OBRA '87 addresses the critical need for more effective and productive enforcement tools in the certification process. The new law appears to shift the emphasis of survey and enforcement from withholding payment and closing homes which are out of compliance with standards to an approach which emphasizes solving quality problems so that nursing homes may remain open for the residents.

The Department of Health strongly supports the need for intermediate sanctions. In the past, we have had only one tool -- decertification or license revocation -- for dealing with problems of poor quality in nursing homes. This has caused serious problems. Nursing homes have had little incentive to avoid repeat deficiencies, because they know they will have the opportunity, with impunity, to make corrections after the survey. The introduction of civil monetary penalties, as required in OBRA, can have a tremendous impact on this problem.

In addition, the Department of Health has been frustrated in our efforts to deal with poor quality homes, especially those in which lack of compliance is placing residents in jeopardy. Although we cannot advocate the continued operation of a deficient facility, closing a home often presents problems for the patients.

As a physician, I am very aware of the trauma that relocation causes to many older persons. This problem is compounded by the fact that there may not be enough beds available in the same general geographic location to accomodate all the residents of a home which must be closed or decertified. Having to relocate residents miles away increases the trauma for residents and adds burden to already-stressed and worried family members.

Lack of appropriate sanctions interferes with our ability to effectively enforce the standards. Our concern over relocation trauma makes it difficult to pursue less than life-threatening violations; the fact is that not all violations of licensure or certification standards warrants revocation or decertification. The one penalty currently available just doesn't always fit the crime, and the victims of the current system are the residents.

A related problem with lack of a range of sanctions is that the courts in Ohio often have been reluctant to allow license revocation or decertification, even when the state believes it is the proper enforcement action. We believe this reluctance may be due in part to the fact that the court cannot be shown that there have been progressive sanctions applied. The courts may be more willing to allow closure of a bad home if they are reassured that closure is the last enforcement step taken by the state, rather than the first.

The intermediate sanctions required or permitted by OBRA, including the ability to use monitors, temporary managers and to take receivorship of a facility, will greatly improve our ability to deal effectively with quality of care problems. These tools will increase our ability to improve conditions in a home where there is jeopardy, minimizing the need for relocation of residents.

The Department of Health will propose that the OBRA intermediate sanctions for nursing home enforcement be incorporated into the state's nursing home licensure law. To make the OBRA enforcement provisions a reality in Ohio, the state must enact major legislative reform over the next several months. Again, final guidelines from the Health Care Financing Administration are needed to allow effective and timely compliance with the intent and letter of the new law.

I strongly urge that the federal government, especially the Health Care Financing Administration, view the states as a partner in the implementation of OBRA. The state survey and Medicaid agencies need to be involved in the development of the standards and regulations, and also in identifying priorities for implementation at the state level.

I commend Congress for the quality of care reforms contained in OBRA '87. I urge not only your continued oversight of the implementation of these reforms, but your financial support of this effort as well. Reform is necessary, but it cannot be done without commitment of additional resources at both the state and federal level. Ohio has estimated that the cost of OBRA implementation in the state over the next biennium will be $41 million dollars in state funds.

I would like to make a final comment regarding the long-term care system in Ohio. It is clear that a major challenge facing Ohio and the nation -- one that is not addressed in OBRA '87 -- is the need for alternatives to nursing home care. Nursing homes are a necessary and valuable provider of long-term care services, but not every elderly or otherwise impaired person can best be served in this setting.

Governor Richard F. Celeste has proposed in his executive budget that Ohio begin to build and encourage community alternatives for long-term care. These proposals include the expansion of the PASSPORT Medicaid waiver program to allow home care, the licensure of adult board and care facilities, and expansion of services like home-delivered meals and transportation help the elderly to continue to live in their own homes or in the community. These are important efforts which could benefit from enhanced support from Congress. The availability of community-based alternatives to nursing homes care not only allows many elderly to be cared for more cost-effectively, but results in a better quality of life.

I thank you for your time and attention.

HEARING ON CONDITIONS IN NURSING HOMES:
The following testimony is herewith submitted to the Honorable Howard Metzenbaum, United States Senate, in conjunction with the Hearing conducted by the Senator on February 25, 1989 at Willow Brook, Worthington, Ohio, by Jerald D. Richmond, Ph.D., Cincinnati, Ohio.

Senator Metzenbaum:

Thank you for the opportunity to present this testimony. It is my fervent hope and prayer that it will serve to better conditions and to encourage the development of alternatives for the millions of American citizens who face and who endure nursing home confinement in The United States. Present conditions are little more than a cause for National shame.

The most definitive conclusion which I can offer the Senator is that, in its present state, nursing home confinement and the indignities to which it subjects both the person confined and his or her caregiver(s) or family is something which should be avoided if at all possible. Given our present system, however, the reality is that, as shown by valid studies, one in four Americans will face confinement in a nursing home prior to departing this life.

My mother, Agnes M. (Raney) Richmond, 85, is a victim of Alzheimer's disease, has Parkinson's symptoms, and other medical complications. She is an Ohio retired teacher (Three Rivers Local School District, Hamilton County, Ohio) who also taught in the one-room schools of her native Ripley County, Indiana during her youth. She was honored for more than forty years service to Lincoln Park Baptist Church, Cincinnati, as a teacher and Departmental Superintendent. In short, she was--and remains--a sensitive, caring, and giving individual, one whose beautiful smile still brightens the lives of those who show her love.

Since February, 1985, she has been confined in nursing homes three times. She now lives in the Health Center of Twin Towers Retirement Community in Cincinnati, Ohio and has done so since February 11, 1987, when a lack of funds resulted in her eviction by the private-for-profit Clovernook Nursing Center in North College Hill, (Cincinnati) Ohio. When our funds ran out, this home refused to accept her Medicaid eligibility and threatened--in writing and verbally--to attempt placement in "...any available bed."

There is evidence that, when money ran out, she became the helpless victim of mental abuse and threats when I was not present. (This became evident in January, 1988 when, in the presence of competent medical personnel, she "relived" the entire eviction experience and the fear which she held within her.

Insofar as possible, her story has been made public. The Senator has visited her and has paid tribute to her on the floor of the United States Senate.

Her story has been a factor, through its public exposure, in hastening the new and landmark long-term care plan now in force through the State Teachers Retirement System of Ohio. The Cincinnati Enquirer has stated editorially that this plan has far-reaching National implications and that it is now in force in at least two other states. The plan will help countless numbers of families avoid what I can only describe as the "...pure living hell" to which both Agnes Richmond and I have been subjected in now more that four years.

We have tried every avenue open to us: Agnes Richmond was the victim of what can only be called, in its kindest form, "neglect" by the physician in Versailles, Indiana (where she and my father, the late Carl H. Richmond, had returned to retire in 1972. My father died on November 22, 1978--six years to the date they had moved to Versailles). As mother's condition developed, we tried nursing home, home care, adult day care and, finally, were forced to accept "custodial care" in a nursing home.

I have personally visited one "medicaid-certified" nursing home in Cincinnati, the only "medicaid bed" available in February, 1986 where the odor was so foul as to almost cause one to vomit. I saw firsthand the dejected and the despairing look on the faces of "residents." I experienced the callous and hard-line attitude of the "admissions counselor" who took a "...take it or leave it" attitude. This was Summit Hursing Home in Cincinnati. I left it. We had, just a few days earlier, undergone the public auction of the contents of her former gracious home in Versaills. These few thousand dollars permitted me to pay for her care at Clovernook, which, at the time, offered a "night and day" difference in environment.

Two points must be stressed at this time:

1. Nursing home confinement, given our present system, is almost inevitable, since, in the name of "cost containment" and HHS-mandated guidelines, ill persons are discharged from hospitals--hospitals with empty beds--long before they are well.
2. Those who perform the most imtimate and personal of services for our elderly ill in nursing homes are the aides or nursing assistants. They are also the most poorly paid. Many, perhaps the great majority, have genuine compassion and caring. Some should never have been hired in the first place. They often work understaffed and in a negative

environment which sees them penalized and even dismissed for refusal to work under situations which render them less than effective.

There is and there are loving and caring persons in the most marginal of homes. These folks stand out, whether they be residents or employees.

The fact is that those residents who have an advocate--a family member or a friend--will receive the best attention in nursing homes. They are, whether they be "private" or "philanthropic" very dollar-driven. There are short cuts in staffing, short cuts in supplies, and short cuts in care which means that, while minimal standards may be maintained and human life may be prolonged, it is done at the expense of basic human dignity which should be the birthright--and the liferight and the deathrite--of every American citizen.

My own dear mother has suffered indignities to her person and to her mental state which should never have occurred. This can range from an aide who verbally or physically abuses a residnet (when no one is looking) through something so simple as harsh treatment in toileting to an administrator who, in search of dollars, subjected both my mother and I to the mental anguish of serving court documents on her and on me twice during the evening meal hour (Nov. 14, 1988 and December 1, 1988) at Twin Towers. I have endured attempts at intimidation--both verbal and written--at Clovernook and at Twin Twoers. I have been threatened--both verbally and in writing--with legal and other actions by the Twin Towers administrator and others.

I have seen nursing staff who care very deeply about a patient and his or her family. I also remember vividly the nursing supervisor at Twin Towers who, on November 14, 1988, saw my mother sobbing in my arms from what we had been forced to endure and who, when the matter was called to her attention said: "Jerry, it's better if I don't know anything about that" and then turned and walked away.

I have seen meals that people could not eat placed in front of them, and a staff who genuinely cares attempt to feed them but, given their numbers, are inadequate to the task.

We have, again in a search for dollars, been forced to undergo the humiliation of Twin Towers' attempt to gain a guardianship of my mother's "person and estate." We were in court on December 22, 1988. Resources were and remain at "zero." Yet, the home had suddenly and without warning demanded more money from us, despite an agreement--which I had, in trust, neglected to request in writing. This Home did indeed obtain a guardianship of my mother's "estate"--which has netted them an additional $22.50 per day in revenue. They failed in their attempt to obtain control of her "person." The axe has fallen on me--but we were again able to walk away in dignity. The home, however, did not succed in a legal maneuver which would have permitted them to alter the care and the treatment prescribed by her private and personal physician, Paul G. Geiss, M.D. the Cincinnati internist and cardiologist who has known and cared for us as a family for some twenty-five years. It is he who, literally, saved my mother's life in January, 1985 from a mis-diagnosis and the neglect from her Versailles, Indiana physician. I have experienced the shock of learning, almost by accident, that charge nurses were uncertain of whom to call if a medical emergency were to befall my mother, Agnes Richmond. All the facts surrounding this matter have not as yet come to light, but I am, at the least, aware that certain actions by Twin Towers were a direct violation of the Ohio Revised Code--and possibly United States Code as well.

I could add that the greed which apparently motivates the Clovernook ownership has driven them to pursue me in the courts for now more than two years--all over a sum of $3200 more or less.

I could add that my mother and I had seen my dear and gentlemanly father through no less than three nursing home confinements--and more than thirty hospitalizations.

The point which I wish to make is that there are relatively few who will escape what Robert Webb, writing in The Cincinnati Enquirer called "The Terror of Long-Term Illness" should they become so unfortunate as to become ill and elderly in the United States. They--and their family if that person or persons is willing to put himself or themselves on the line--will be completely wiped out in relatively little time. Along the way, they will encounter competent and caring individuals and health care professionals. They will also encounter greed, underhanded and viciousbehavior and lies, and conditions--such as me learning that my mother has sores on her little bottom because she was left to sit too long in a soiled diaper or the Clovernook and Twin Towers legal maneuvers--all done under the guise of health care and one under a false cloak of Christianity.

Senator, all the facts concerning my mother's ordeal and the agonies which I have lived have not as yet come to light. This country needs take a look and then act to provide the dignity to which all Americans should have a right.

One colleague, a distinguished political figure in Hamilton County and Ohio, told me that I could write a book and that the title ought to be:

Health Care in the United States: Things I Never Wanted to Know.

My mother and I have undergone a living Hell, but I have also learned to appreciate and to understand and to cherish her inner beauty and the genuiness of her existence. You see, the nursing administration sees "reality" as an old person who has probably lived long enough and who ought to suffer the "benevolent neglect" which would let her die...either sooner or later. I see naegativism practiced where positivism is preached. But I also know that I am and must be an advocate for my mother. She never gave up on me or on my father. I will never give up on her. Neither have the many who are holding us up in prayer. Neither has her caring and competetent physician.

Neither, Senator, have you. I applaud you for conducting this kind of hearing. I only wish that there were more that I could do and that my mother's story of both sadness and beauty could have the attention it deserves. Agnes Richmond remains a nominee for the most prestigious award given by her alma mater, Miami University, for exemplary service to humanity. She deserves it. She should never be subjected to the indignities and the abuse forced on her. She deserves and merits the finest care and all the love which can be shown her. The same is true of all American citizens.

Thank you.

Respectfully,

JERALD D. RICHMOND, Ph.D.

February 25, 1989

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Phone: (513)662-2082

WRITTEN
TESTIMONY TO
SUB-COMMITTEE ON AGING
CHAIRED BY SENATOR HOWARD METZENBAUM
HEARING
ON
CONDITIONS IN NURSING HOMES: PROTECTING CONSUMER INTERESTS

Saturday, February 25, 1989

BY

HENNY MOREHOUSE, Past Chairman, OHIO ALZHEIMER'S COALITION

and

MEMBER OF NATIONAL ALZHEIMER'S PUBLIC POLICY COMMITTEE

SENATOR METZENBAUM:

My name is Henny L. Morehouse. I am the Ohio Representative to the Alzheimer's Disease Public Policy Committee. I am writing at the request of Nancy Lombardo, Vice-President for the National Alzheimer's Disease Board and Chairwoman for the National Public Policy Committee.

I am by training and by profession a Licensed Nursing Home Administrator and a Licensed Independent Social Worker in Ohio. I currently am the Administrator of a 177 bed County Facility in the Cleveland area. I also have worked with, for and on behalf of the elderly for over nineteen (19) years, both at community-based settings as well as in institutionally-based settings. I have served the Alzheimer's Disease cause as a Chapter Trustee since 1981. Additionally, I was a family member.

Alzheimer's Disease is the most common form of dementia, a progressive, irreversible disease that attacks the brain and gradually strips away a person's mental and physical capacities. Typical symptoms include gradual memory loss, disorientation, impaired judgment, and in its final stages loss of control of bodily functions. The course of the disease normally runs from three to more than twenty years. Alzheimer's is the fourth leading cause of death. The cause of the disease has not been determined.

Alzheimer's Disease afflicts individuals of every social and economic strata. An estimated 7 to 9 percent of persons over age 65 (25% of those individuals over age 85) have the disease, but it is not exclusively a disease of the old. Fifteen per cent. of persons over the age of 65 have a mild, moderate or severe form of Alzheimer's or a related disorder.* As more and more people live to an older age,the incidence of Alzheimer's Disease will rise dramatically; a five-fold increase is expected by the year 2040. At least 25% of Americans now in their 20's and 30's will develop Alzheimer's Disease before they die, unless we find a cure. The total economic cost to society, now estimated to be over $80 Billion annually**, also will increase in proportion to the number of people afflicted.

The Alzheimer's Association has five major goals reflected in its mission statement:

1. Supporting research into the cause, treatment, cure and prevention of Alzheimer's Disease and related disorders.
2. Stimulating education and awareness of the disease among the general public and professionals.
3. Establishing the formation of a nationwide family support network of chapters and support groups.
4. Advocating for public policies that address the needs of patients and their families and caregivers.
5. Enhancing the quality, availability, access to and appropriateness of services for patients and caregivers.

Alzheimer's and related disorders patients constitute nearly two-thirds of the nursing home population and perhaps one-third to one-half of the home-based long term care population. Approximately 70 to 80% of long term care services are provided by informal caregivers at home, often families and friends. The lack of available, affordable services is a particular problem for our patients and their families, individuals who are placed under tremendous stress because of the progressive nature of the disease, its often long duration and the difficulties of caring for dementia patients.

Caregivers are often faced with pitting the care needs of the Alzheimer's patient against the other demands made upon them by other members of their family, their employers and the general community. In the early stages of the disease outsiders may not be aware of the severity of the patient's condition: the person may look as though they are "fine" since, usually, no physical symptoms are exhibited. Meanwhile, even during these early stages family caregivers are tormented by the reality that their ill relative is not functioning normally and that their minds, abilities and personalities are disintegrating. Even in the early stages, patients may need constant supervision in order to protect themselves and others from danger. As the disease progresses, patients lose more and more cognitive abilities and may develop a variety of inapproprriate behaviors which compound the difficulties of caring for them. Eventually patients lose the ability to understand, recognize people, talk, walk and take care of basic bodily functions. At some point in the disease family caregivers may find they can no longer care for the patient at home and face the difficult decision of institutionalizing the patient. For the vast majority of families, this is the last, exceedingly painful, resort and many families continue to be actively involved in the care of the patient while they are in the nursing home. One should also note that studies have shown that many Alzheimer patients do not have families and that as many as 25% of even severely demented patients are living alone at great risk to the safety of themselves and others.

Sixty-three per cent. of the current residents of nursing homes, or 940,000 persons in 1985, experience cognitive impairment primarily due to having some form of dementia.*** The average annual cost of nursing home care in 1985 was $25,000, an amount which rapidly exhausts the resources of all but the most wealthy. The current Medicaid program requires patients and their spouses to impoverish themselves before they are eligible for assistance and, in effect, encourages the dissolution of families.

Currently the nation's health care system is poorly equipped to deal with the growing number of people suffering from Alzheimer's. Health care, respite care, and other support services are hard to get, and the range of available services often fails to meet the needs of patients or caregivers. Not enough physicians, nurses, social workers, nursing home aides or home health aides are adequately trained in how best to care for persons with dementia.

NURSING HOME REFORM

Alzheimer's Association Public Policy Committee Chair, Nancy Lombardo, and others have worked very closely for the last couple of years with the National Coalition for Nursing Home Reform to help influence and interpret nursing home reform legislation introduced through Omnibus Budget Reconciliation Act of 1987 (O.B.R.A.). Overall, this legislation will have a profound impact, nationwide, on patients rights, quality of care, and minimum standards of care in a nursing home setting. Unfortunately, Health Care Financing Administration (H.C.F.A.) has not provided the leadership necessary to effect these changes in a smooth, non-disruptive manner. The preadmission screening requirement in O.B.R.A., for example, was effective January 1, 1989, but no criteria or guidelines from H.C.F.A. was forthcoming then and it is not expected for many months to come. Consequently, all states are forced to interpret their own criteria and we have chaos that causes only the consumer to suffer. The consumer now must wait an additional two to four weeks in discomfort and sometimes confusion until we professionals determine whether the consumer is either mentally retarded or mentally ill. Think about it. This consumer is typically an 84 year old individual, probably female, who raised 2.5 children and either managed a home or worked or both most of her life. She's declined due to physical causes, most probably, but recently became quite depressed due to a diagnosis of cancer (50% of elderly) and was hospitalized for an evaluation. This evaluation suggested a need for placement in an Intermediate Care Facility. Because of the three week hospitalization, her primary diagnosis is acute depression. She must be screened at Level II. This cancer victim runs the risk of institutionalization in a Mental Illness Facility! If this person also had a diagnosis of dementia, not at all uncommon, it would be tertiary and not even considered.

Patients with a depression secondary to Alzheimer's (or progressive dementias) also run the risk of inappropriate placement. Generally, with dementia patients who are also depressed should be placed according to the long term or chronic problem, but these individuals are entitled to receive treatment for the depression by a properly trained mental health professional in the nursing home, where the dementia should be adequately managed as well. This is not being addressed at all by the Health Care Financing Administration.

Dementia does occur in persons who are mentally retarded. Both the dementia and mental retardation conditions should be considered with regard to both treatment and placement decisions.

Further, the use of the terms or concepts of primary, secondary or tertiary diagnoses is inconsistent with the proper use of DSM III criteria and procedures.

DMS III uses multiple axes including axis 1 - mental disorder, axis 2- mental retardation, and axis 3- medical illness. Diagnoses on different axes are given equal weight; there is no hierarchy among diagnoses. Multiple diagnoses on the same axis are given equal weight. Multiple diagnoses simply indicate the patient has difficulties in multiple spheres.

OBRA 1987 law states a person "is considered mentally ill if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition" and does not have a primary diagnosis of dementia...." Thus legally the information needed to make the diagnostic determination for PASARR must be the diagnostic criteria used in the DSM-III.

Following DSM-III criteria, it logically follows that a person who has any diagnosis of dementia cannot, by definition, be diagnosed as also mentally ill; the only exception allowed is in some cases of depression. DSM-III states, "the diagnoses (of mental illness) is made only when it cannot be established that an organic factor initiated and maintained the disturbance." These organic factors include two large groups of problems (1) dementia and (2) delirium. Further, dementia patients are vulnerable to delirium. Thus, according to DSM-III the diagnosis of any individual as being mentally ill cannot be made without first ruling out both delirium and dementia*.

*(1) See references attached.

THUS IF THE LEGAL REQUIREMENT OF FOLLOWING DSM III CRITERIA IS ADHERED TO IN DIAGNOSING MENTAL ILLNESS, ALL DEMENTIA PATIENTS, WHETHER PRIMARY, SECONDARY OR TERTIARY OR WHATEVER, SHOULD BE EXCLUDED FROM PASARR.

Overall, I need to express my concern and sadness at the hardships that these new regulations are causing to individuals already over-burdened with their life changes which are overwhelming even under kinder circumstances.

I have reviewed other testimony presented to the Sub-Committee on Aging on February 25, 1989 and, in particular, that of the National Citizens Coalition for Nursing Home Reform since I was unable to attend the actual hearing. I found myself in full agreement with its contents. As a Nursing Home Administrator, and as one who is very concerned about the plight of dementia victims and the elderly, I hope these conditions will be addressed by appropriate persons as soon as possible.

Further, it is my belief that with the new OBRA legislation and the nursing home reform that follows, that there will be major changes in the nursing homes in the country. Most probably there will be an increase in acuity level at the nursing homes and meaning that the individuals coming to nursing homes will be much sicker, will be there for shorter periods of time, and will be needing much more skilled and specialized services. Secondly, the cost of providing these services will probably increase substantially as the population increases in age. The nursing home industry will be at risk financially or provide fewer services or reduce the quality of services, unless the costs can be stabilized so that they are totally reimbursed for cost of care.

In summary, I must observe that although half or more residents in a nursing home have some degree of dementia, here management and treatment services are made available the least! Nurses Aids are not trained in basic communication methods with the elderly, who have reduced ability to hear, to see and to touch, let alone those who are demented and have impaired ability to interpret information and act on it. Abuses to these individuals run rampant in both subtle and overt ways ranging from excessive use of restraints to gross verbal abuse to verbal ridicule. The quality of care changes that hopefully will come out of this Nursing Home Reform Legislation should not be hindered in any way by lack of adequate funding to assure the level of quality care that we wish for our family members and the spirit of the legislation should clearly be interpreted as also enhancing the quality of life for the large numbers of people who are victims of dementia. We, you, the reader and I, will one day, if we live long enough, be subject to the same psychological pain as these victims are now. It is my hope that these inequities are corrected today.

References:

For page 2

* The DHHS Advisory Panel on Alzheimer's Disease draft Introduction p. 1."The number of persons with dementia is difficult to determine percisely, and is generally estimated by applying a percentage found in studies of a particular community to general U.S. Census figures for the aged.... The research literature in geneal has indicated that from 4-7 percent of the population over age 65 shows severe dementia and that similar or larger proportion shows milder degress of dementia. Cross and Gurland (1986) summarized these findings an indicating severe dementia in 1 percent of teh popultion aged 65-74, in 7 percent of those 75-84, and 25 percent of those 85 or older. If the overall prevalence is conservatively estimated at 15 percent, this represents approximately 4.5 million of the current 30 million citizens over age 65." Cross, P.S. & Gurland, Barry J. (1986). The Epidemiology of Dementing Disorders," Contract report prepared for the Office of Technology Assessment, U.S. Congress.

** Huang, Cartwright and Hu, 1988 estimate that senile dementia cost the American economy nearly $88 billion in 1985 (direct and indirect costs). Huang,L.-F., Cartwright, W.S., & Hu, T.-H. (1988) The Economic Cost of Senile Dementia in the United States, 1985. Public Health Reports, 103 (1,January-February),3-7.

*** 1985 Nursing Home Survey; preliminary reports from NCHS

2909 Green Vista Drive
Fairborn, Ohio 45324
March 8, 1989

Sen. Howard Metzenbaum
1240 East Ninth Streets
Room 2915
Cleveland, Ohio 44114

Dear Senator Metzenbaum,

After receiving a notice regarding a hearing concerning complaints your office has been receiving about nursing homes, the coordinator for our Long Term Care Ombudsman Program requested my name be added to the agenda of speakers. Unfortunately, the available slots for speakers was already full. For that reason, I am sending a letter about my concerns in the hope that these comments can be included with those made at that hearing.

About five years ago, I was one of a group of family members, volunteers and nursing home workers who filed complaints in protest of existing conditions and violations against residents' rights at a local nursing home. Our complaints concerned very specific conditions within the home. We reported personally observing actions which called attention to which residents were Medicaid; disregard for residents' privacy or modesty during periods when they were moved into the hallway during redecorating renovation; use of varnish and varnish remover in unventilated areas during winter months, causing distress to patients with breathing problems; screening of outgoing mail from one patient who did not want to be a patient and who had difficulty getting his letters past office staff to mailman; preference given to private pay applicants; lack of consideration for the rights of free movement of residents during an open house to display the above mentioned renovation to the public (on several occasions, residents had to eat from paper plates in their rooms so the home could entertain local dignitaries, and on one occasion in particular, they were restricted to their rooms during an open house) We also filed a complaint that the Administrator chastized both residents and families for complaining about any problem, telling both they could leave if they didn't like it.

I originally brought these conditions to the attention of our Greene County Human Services and to our local congressman and later handcarried letters of backup documentation to his office. As a result, there were several investigative teams from the State of Ohio, including Health Department and Medicaid. None of our complaints were substantiated. Unless the investigator saw the infraction, it could not be validated. Even the complaints about unappetizing and poor quality food were never proven. The Health Department looked at the printed menus and declared the food adequate. The patients who were brave enough to complain about the food during inspections were considered to be chronic complainers and their statements were disregarded.

Our complaints were also discounted because in many instances, we had not documented time and date. The one that did get action was concerning the Administrator of that home. At a meeting with the regional manager of the corporation, we listed specific details of times when she had scolded patients, made veiled threats, and told both patients and family members if they didn't like what happened, they could leave. The corporation transferred her to another home in Florida with a promotion. In response to charges of Medicaid discrimination, the regional manager informed us if you pay more, you should get more. As I understand nursing home legislation, this is against the law, however we found it could not be enforced.

Although I realize that nothing can be done about complaints that happened five years ago, these situation still exists. It is extremely difficult to substantiate claims by residents or their families. Dispite what we read about Residents Rights and laws against abuse, when residents complain about what happened yesterday, validation is difficult tomorrow.

During the latter part of 1984, after attending orientation given by Dayton Long Term Care Ombudsman concerning Residents Rights, I became a volunteer for that office. I currently work one day a week maintaining files and taking and recording complaints. I receive repeated complaints from family members, residents themselves and employees. Those from families include statements that incapacitated patients aren't turned regularly, incontinent residents aren't being changed often enough, and weak or disoriented residents are not receiving the necessary time or assistance in eating before food trays are removed. Calls from residents state that some aids are rude, call buttons are ignored or not answered for long periods, food is unappetizing with residents given choice of eat it or go hungry - substitutes, if any, are no better and little consideration is given to special diets for diabetics to make sure they have enough food to utilize insulin. Calls from employees reflect that it is often policy to complete records regarding patient care at the end of the shift, with as much data from what should be there as what really happened, that they are concerned when some patients have unexplained bruises that are not recorded, and that they are put into a situation of patient neglect due to understaffing.

In case this sounds as though I am anti-nursing home - I'm not. During my association with nursing homes over the years, I have gained respect for many nurses and aids and am convinced nursing homes serve a very necessary function in the care giving of many of our elderly. But they are run by people and when you have a situation where a number of people have control and the right to make decisions concerning another group of people, there are bound to be problems.

My mother went to a local nursing home from the hospital in mid 1981, and I was in that home at varying times of day, four or five days a week. I saw the good and the bad and what was swept under the rug. There were times when I was frustrated at decisions made at top level, at charges added to cost of services provided by another health care agency, visits by doctors when they consulted with the nurses but sometimes did not see the patient and inconsideration from hands-on personnel. I heard aids scold residents for frequent use of call buttons, even though the need for assistance was legitimate, saw urine on the floor when that call button wasn't answered, observed the short staffing, burnt food and vegtables overcooked until it looked like mush that went from the residents' plates to the dumpster because they wouldn't eat it. According to guidelines set down by the State of Ohio, a nursing home ratio of staff to resident is so low (with some employees assigned to housekeeping or kitchen counted as aids) that the aids that are really on duty have to trot from one patient to another to get them up in the morning and washed, dressed and fed. Something has to give. In this case, that something is not just quality of care, but quality of life.

Nursing home residents have the Residents' Bill of Rights and the new Nursing Home laws which help protect those rights. However, until we are able to substantiate complaints when rights are violated and institute adequate disciplinary measures, these rights mean little to the nursing home resident. Closing the homes only shifts the residents from one place to another that has its own set of problems. For this reason, I urge you to sponsor legislation which sets higher standards regarding staff ratio including stipulations that all the hours charged to hands-on personnel are spent with residents and not in the laundry, housekeeping or kitchen, stricter regulations to guarantee that patients' needs are met, and more severe disciplinary actions and/or monetary penalities when decisions are made that diminish the residents' quality of life in the name of profit.

Sincerely,

Nina L. Beane

NINA L. BEANE

Senator **Metzenbaum**. With that, many of you are probably getting hungry. It is ten minutes to 2:00. We have been here since 11:00 o'clock.

I thank you very much, and the hearing stands adjourned.

[Whereupon, at 1:50 p.m., the Subcommittee was adjourned.]

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